

103^D CONGRESS
2^D SESSION

H. R. 150

To amend the Internal Revenue Code of 1986 to improve access to health care, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 5, 1993

Mr. HASTERT (for himself, Mr. GOSS and Ms. FOWLER) introduced the following bill; which was referred jointly to the Committees on Ways and Means, Energy and Commerce, and the Judiciary

JANUARY 27, 1994

Additional sponsors: Mr. GALLEGLY, Mr. BAKER of Louisiana, Mr. HERGER, Mr. COX, Mr. SUNDQUIST, Mr. EMERSON, Mr. KYL, Mr. MACHTLEY, Mr. McKEON, Mr. LEWIS of Florida, Mr. SENSENBRENNER, Mr. ZELIFF, Mr. KINGSTON, and Mr. BALLENGER

A BILL

To amend the Internal Revenue Code of 1986 to improve access to health care, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Health Care Choice and Access Improvement Act of
6 1993”.

7 (b) TABLE OF CONTENTS.—

Sec. 1. Short title and table of contents.

TITLE I—FAMILY HEALTH AND WELLNESS SAVINGS PLAN

Sec. 101. Medical savings accounts.

Sec. 102. Unused amounts in flexible spending accounts transferable to medical savings accounts.

Sec. 103. Deduction for amounts paid for qualified catastrophic coverage health plan.

TITLE II—TAX TREATMENT OF LONG-TERM CARE INSURANCE AND PLANS

Subtitle A—Treatment of Long-Term Care Insurance

Sec. 201. Qualified long-term care insurance treated as accident and health insurance for purposes of taxation of life insurance companies.

Sec. 202. Qualified long-term care insurance treated as accident and health insurance for purposes of exclusion for benefits received under such insurance and for employer contributions for such insurance.

Sec. 203. Exclusion from gross income for amounts withdrawn from individual retirement plans or 401(k) plans for qualified long-term care insurance.

Sec. 204. Exchange of life insurance policy for qualified long-term care policy not taxable.

Subtitle B—Employer Funding of Medical Benefits

Sec. 211. Medical benefits for retired employees and their spouses and dependents.

Sec. 212. Treatment of health benefits accounts.

Subtitle C—Reverse Mortgage Insurance for Older Americans

Sec. 221. Maximum amount insured.

Subtitle D—Income Tax Credits

Sec. 231. Refundable credit for custodial care of certain dependents in taxpayer's home.

Sec. 232. Credit for expenses for long-term care services provided to certain independent persons requiring such care.

Subtitle E—Treatment of Accelerated Death Benefits

Sec. 241. Tax treatment of accelerated death benefits under life insurance contracts.

Sec. 242. Tax treatment of companies issuing qualified accelerated death benefit riders.

Subtitle F—Federal National Long-Term Care Reinsurance Corporation

Sec. 251. Authorization for establishment of Corporation.

Sec. 252. Board of directors and officers.

Sec. 253. Purpose and authority of Corporation.

Sec. 254. Capitalization.

Sec. 255. Exemption from state regulation and taxation.

Sec. 256. Audit and annual report.

- Sec. 257. Protection of name.
- Sec. 258. Termination.

TITLE III—MALPRACTICE LIABILITY REFORM

- Sec. 301. Definitions.
- Sec. 302. Malpractice liability reform requirements described.
- Sec. 303. Waiver of requirements for good cause or for carrying out demonstration projects.
- Sec. 304. Certification of state compliance.
- Sec. 305. Incentives through Medicare and Medicaid.
- Sec. 306. Applicability of certain provisions to Federal Tort Claims Act.
- Sec. 307. Rules of construction.

TITLE IV—WORKING AMERICANS ACCESS TO HEALTH CARE

Subtitle A—Increase in Small Employer Access to Affordable Health Insurance

- Sec. 401. Establishment and enforcement of standards for small employer health insurance plans.
- Sec. 402. Preemption of state benefits mandates for plans that meet consumer protection standards.
- Sec. 403. Requirement for offering of basic, low cost plan (medequity plan).
- Sec. 404. Requirements relating to initial writing of policies.
- Sec. 405. Requirements relating to renewal.
- Sec. 406. Establishment of reinsurance mechanisms for high risk individuals.
- Sec. 407. Registration of all health benefit plans required.
- Sec. 408. Definitions.
- Sec. 409. Preemption from insurance mandates for qualified small employer purchasing groups.

Subtitle B—Equalization of Tax Benefits for Self-Employed Persons Under Certain Plans

- Sec. 411. Equalization of tax benefits for self-employed persons under certain plans.

Subtitle C—Managed Care Rights

- Sec. 421. Managed care rights.

Subtitle D—Study and Report

- Sec. 431. Study and report on impact.

TITLE V—ADMINISTRATIVE COST SAVINGS

Subtitle A—Standardization of Claims Processing

- Sec. 501. Adoption of data elements, uniform claims, and uniform electronic transmission standards.
- Sec. 502. Application of standards.
- Sec. 503. Periodic review and revision of standards.
- Sec. 504. Health benefit plan defined.

Subtitle B—Electronic Medical Data Standards

- Sec. 511. Medical data standards for hospitals and other providers.

- Sec. 512. Application of electronic data standards to certain hospitals.
- Sec. 513. Electronic transmission to Federal agencies.
- Sec. 514. Limitation on data requirements where standards in effect.
- Sec. 515. Advisory commission.

Subtitle C—Development and Distribution of Comparative Value Information

- Sec. 521. State comparative value information programs for health care purchasing.
- Sec. 522. Federal implementation.
- Sec. 523. Comparative value information concerning Federal programs.
- Sec. 524. Development of model systems.

Subtitle D—Additional Standards and Requirements; Research and Demonstrations

- Sec. 531. Standards relating to use of Medicare and Medicaid magnetized health benefit cards; secondary payor data bank.
- Sec. 532. Preemption of State quill pen laws.
- Sec. 533. Use of standard identification numbers.
- Sec. 534. Coordination of benefit standards.
- Sec. 535. Research and demonstrations.

1 **TITLE I—FAMILY HEALTH AND** 2 **WELLNESS SAVINGS PLAN**

3 **SEC. 101. MEDICAL SAVINGS ACCOUNTS.**

4 (a) IN GENERAL.—Part VII of subchapter B of chap-
5 ter 1 of the Internal Revenue Code of 1986 (relating to
6 additional itemized deductions for individuals) is amended
7 by redesignating section 220 as section 221 and by insert-
8 ing after section 219 the following new section:

9 **“SEC. 220. MEDICAL SAVINGS ACCOUNTS.**

10 “(a) DEDUCTION ALLOWED.—In the case of an eligi-
11 ble individual, there shall be allowed as a deduction
12 amounts paid in cash during the taxable year by or on
13 behalf of such individual to a medical savings account.

14 “(b) LIMITATION.—

1 “(1) IN GENERAL.—The amount allowable as a
2 deduction under subsection (a) to an individual for
3 the taxable year shall not exceed the excess (if any)
4 of—

5 “(A) the lesser of—

6 “(i) the applicable limit, or

7 “(ii) the compensation (as defined in
8 section 219(f)) includible in the individ-
9 ual’s gross income for the taxable year,
10 over

11 “(B) the sum of—

12 “(i) the value of employer-provided
13 coverage for the medical expenses of such
14 individual,

15 “(ii) the amount paid by the individ-
16 ual (other than from amounts distributed
17 from a medical savings account) for cov-
18 erage under qualified catastrophic coverage
19 health plan for coverage for such individ-
20 ual, the spouse of such individual, and de-
21 pendents (as defined in section 152) of
22 such individual, plus

23 “(iii) the aggregate amount contrib-
24 uted to such account during the taxable
25 year pursuant to section 125(d)(3).

1 “(2) APPLICABLE LIMIT.—For purposes of
2 paragraph (1), the applicable limit is the sum of—

3 “(A) \$4,800, plus

4 “(B) \$600 for each individual who is a de-
5 pendent (as defined in section 152) of the indi-
6 vidual for whose benefit the account is estab-
7 lished.

8 “(c) DEFINITIONS AND SPECIAL RULES.—For pur-
9 poses of this section—

10 “(1) MEDICAL SAVINGS ACCOUNT.—The term
11 ‘medical savings account’ means a trust created or
12 organized in the United States exclusively for the
13 purpose of paying the qualified medical expenses of
14 the individual for whose benefit the trust is estab-
15 lished, but only if the written governing instrument
16 creating the trust meets the following requirements:

17 “(A) No contribution will be accepted un-
18 less it is in cash and contributions will not be
19 accepted for any taxable year in excess of the
20 applicable limit (as defined in subsection
21 (b)(2)).

22 “(B) The trustee is a bank (as defined in
23 section 408(n)) or another person who dem-
24 onstrates to the satisfaction of the Secretary
25 that the manner in which such person will ad-

1 minister the trust will be consistent with the re-
2 quirements of this section.

3 “(C) No part of the trust assets will be in-
4 vested in life insurance contracts.

5 “(D) The assets of the trust will not be
6 commingled with other property except in a
7 common trust fund or common investment
8 fund.

9 “(2) ELIGIBLE INDIVIDUAL.—The term ‘eligible
10 individual’ means any individual if—

11 “(A) such individual is not covered by any
12 employer-provided group health plan, or

13 “(B) such individual is covered by an em-
14 ployer-provided group health plan which is a
15 qualified catastrophic coverage health plan and
16 is not covered by any other health plan.

17 “(3) QUALIFIED MEDICAL EXPENSES.—

18 “(A) IN GENERAL.—The term ‘qualified
19 medical expenses’ means—

20 “(i) medical expenses, and

21 “(ii) amounts paid for qualified long-
22 term care insurance (as defined in section
23 818(g)).

24 “(B) MEDICAL EXPENSES.—The term
25 ‘medical expenses’ means amounts paid by the

1 individual for whose benefit the account was es-
2 tablished for medical care (as defined in section
3 213) of such individual, the spouse of such indi-
4 vidual, and any dependent (as defined in section
5 152) of such individual, but only to the extent
6 such amounts are not compensated for by in-
7 surance or otherwise.

8 “(4) QUALIFIED CATASTROPHIC COVERAGE
9 HEALTH PLAN.—The term ‘qualified catastrophic
10 coverage health plan’ means any health plan which
11 is certified by the Secretary of Health and Human
12 Services as a plan—

13 “(A) which provides no compensation for
14 medical expenses not exceeding \$3,000 during
15 any year,

16 “(B) which requires the individual to pay
17 15 percent of such individual’s medical expenses
18 to the extent they exceed \$3,000 but not
19 \$9,000 during any year, and

20 “(C) which provides full reimbursement for
21 medical expenses exceeding \$9,000.

22 “(5) TIME WHEN CONTRIBUTIONS DEEMED
23 MADE.—A taxpayer shall be deemed to have made a
24 contribution on the last day of the preceding taxable
25 year if the contribution is made on account of such

1 taxable year and is made not later than the time
2 prescribed by law for filing the return for such tax-
3 able year (not including extensions thereof).

4 “(d) TAX TREATMENT OF DISTRIBUTIONS.—

5 “(1) IN GENERAL.—Except as otherwise pro-
6 vided in this subsection, any amount paid or distrib-
7 uted out of a medical savings account shall be in-
8 cluded in the gross income of the individual for
9 whose benefit such account was established unless
10 such amount is used exclusively to pay the qualified
11 medical expenses of such individual.

12 “(2) EXCESS CONTRIBUTIONS RETURNED BE-
13 FORE DUE DATE OF RETURN.—Paragraph (1) shall
14 not apply to the distribution of any contribution paid
15 during a taxable year to a medical savings account
16 to the extent that such contribution exceeds the
17 amount allowable as a deduction under subsection
18 (a) if—

19 “(A) such distribution is received on or be-
20 fore the day prescribed by law (including exten-
21 sions of time) for filing such individual’s return
22 for such taxable year,

23 “(B) no deduction is allowed under sub-
24 section (a) with respect to such excess contribu-
25 tion, and

1 “(C) such distribution is accompanied by
2 the amount of net income attributable to such
3 excess contribution.

4 Any net income described in subparagraph (C) shall
5 be included in the gross income of the individual for
6 the taxable year in which it is received.

7 “(e) TAX TREATMENT OF ACCOUNTS.—

8 “(1) EXEMPTION FROM TAX.—A medical sav-
9 ings account is exempt from taxation under this sub-
10 title unless such account has ceased to be an invest-
11 ment savings account by reason of paragraph (2).
12 Notwithstanding the preceding sentence, any such
13 account is subject to the taxes imposed by section
14 511 (relating to imposition of tax on unrelated busi-
15 ness income of charitable, etc. organizations).

16 “(2) LOSS OF EXEMPTION OF ACCOUNT WHERE
17 INDIVIDUAL ENGAGES IN PROHIBITED TRANS-
18 ACTION.—

19 “(A) IN GENERAL.—If, during any taxable
20 year of the individual for whose benefit the
21 medical savings account was established, such
22 individual engages in any transaction prohibited
23 by section 4975 with respect to the account, the
24 account ceases to be a medical savings account
25 as of the first day of that taxable year.

1 “(B) ACCOUNT TREATED AS DISTRIBUTING
2 ALL ITS ASSETS.—In any case in which any ac-
3 count ceases to be a medical savings account by
4 reason of subparagraph (A) on the first day of
5 any taxable year, paragraph (1) of subsection
6 (d) applies as if there were a distribution on
7 such first day in an amount equal to the fair
8 market value (on such first day) of all assets in
9 the account (on such first day).

10 “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-
11 ITY.—If, during any taxable year, the individual for
12 whose benefit a medical savings account was estab-
13 lished uses the account or any portion thereof as se-
14 curity for a loan, the portion so used is treated as
15 distributed to that individual.

16 “(f) ADDITIONAL TAX ON CERTAIN AMOUNTS IN-
17 CLUDED IN GROSS INCOME.—

18 “(1) DISTRIBUTION NOT USED FOR QUALIFIED
19 MEDICAL EXPENSES.—If a distribution from a medi-
20 cal savings account is made, and not used to pay the
21 qualified medical expenses of the individual for
22 whose benefit the account was established, the tax li-
23 ability of such individual for the taxable year in
24 which such distribution is received shall be increased
25 by an amount equal to 10 percent of the amount of

1 the distribution which is includible in gross income
2 for such taxable year.

3 “(2) DISQUALIFICATION CASES.—If an amount
4 is includible in the gross income of an individual for
5 a taxable year under subsection (e), his tax under
6 this chapter for such taxable year shall be increased
7 by an amount equal to 10 percent of such amount
8 includible in his gross income.

9 “(3) DISABILITY OR DEATH CASES.—Para-
10 graphs (1) and (2) do not apply if the payment or
11 distribution is made after the individual for whose
12 benefit the medical savings account was established
13 becomes disabled within the meaning of section
14 72(m)(7) or dies.

15 “(g) SPECIAL RULES.—

16 “(1) COMMUNITY PROPERTY LAWS.—This sec-
17 tion shall be applied without regard to any commu-
18 nity property laws.

19 “(2) CUSTODIAL ACCOUNTS.—For purposes of
20 this section, a custodial account shall be treated as
21 a trust if—

22 “(A) the assets of such account are held by
23 a bank (as defined in section 408(n)) or an-
24 other person who demonstrates to the satisfac-
25 tion of the Secretary that the manner in which

1 he will administer the account will be consistent
2 with the requirements of this section, and

3 “(B) the custodial account would, except
4 for the fact that it is not a trust, constitute a
5 medical savings account described in subsection
6 (c).

7 For purposes of this title, in the case of a custodial
8 account treated as a trust by reason of the preceding
9 sentence, the custodian of such account shall be
10 treated as the trustee thereof.

11 “(3) DENIAL OF DEDUCTIONS.—No amount
12 paid or distributed from a medical savings account
13 shall be taken into account in determining the de-
14 duction provided by section 213.

15 “(h) INFLATION ADJUSTMENT.—

16 “(1) IN GENERAL.—In the case of any taxable
17 year beginning in a calendar year after 1993, each
18 applicable dollar amount shall be increased by an
19 amount equal to—

20 “(A) such dollar amount, multiplied by

21 “(B) the cost-of-living adjustment for the
22 calendar year in which the taxable year begins.

23 “(2) COST-OF-LIVING ADJUSTMENT.—For pur-
24 poses of paragraph (1), the cost-of-living adjustment

1 for any calendar year is the percentage (if any) by
2 which—

3 “(A) the deemed average total wages (as
4 defined in section 209(k) of the Social Security
5 Act) for the preceding calendar year, exceeds

6 “(B) the deemed average total wages (as
7 so defined) for calendar year 1992.

8 “(3) APPLICABLE DOLLAR AMOUNT.—For pur-
9 poses of paragraph (1), the term ‘applicable dollar
10 amount’ means—

11 “(A) the \$4,800 and \$600 amounts in sub-
12 section (b), and

13 “(B) the \$3,000 and \$9,000 amounts in
14 subsection (c)(4).

15 “(4) ROUNDING.—If any amount as adjusted
16 under paragraph (1) is not a multiple of \$10, such
17 amount shall be rounded to the nearest multiple of
18 \$10 (or, if such amount is a multiple of \$5 and not
19 of \$10, such amount shall be rounded to the next
20 highest multiple of \$10).

21 “(i) REPORTS.—The trustee of a medical savings ac-
22 count shall make such reports regarding such account to
23 the Secretary and to the individual for whose benefit the
24 account is maintained with respect to contributions, dis-
25 tributions, and such other matters as the Secretary may

1 require under regulations. The reports required by this
2 subsection shall be filed at such time and in such manner
3 and furnished to such individuals at such time and in such
4 manner as may be required by those regulations.”

5 (b) DEDUCTION ALLOWED IN ARRIVING AT AD-
6 JUSTED GROSS INCOME.—Paragraph (7) of section 62(a)
7 of such Code (relating to retirement savings) is amend-
8 ed—

9 (1) by inserting “OR MEDICAL EXPENSE” after
10 “RETIREMENT” in the heading of such paragraph,
11 and

12 (2) by inserting before the period at the end
13 thereof the following: “and the deduction allowed by
14 section 220 (relating to deduction of certain pay-
15 ments to medical savings accounts)”.

16 (c) TAX ON EXCESS CONTRIBUTIONS.—Section 4973
17 of such Code (relating to tax on excess contributions to
18 individual retirement accounts, certain section 403(b) con-
19 tracts, and certain individual retirement annuities) is
20 amended—

21 (1) by inserting “**MEDICAL SAVINGS AC-**
22 **COUNTS,**” after “**ACCOUNTS,**” in the heading of
23 such section,

1 (2) by redesignating paragraph (2) of sub-
2 section (a) as paragraph (3) and by inserting after
3 paragraph (1) the following:

4 “(2) a medical savings account (within the
5 meaning of section 220(c)),”,

6 (3) by striking “or” at the end of paragraph
7 (1) of subsection (a), and

8 (4) by adding at the end thereof the following
9 new subsection:

10 “(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS
11 ACCOUNTS.—For purposes of this section, in the case of
12 a medical savings account, the term ‘excess contributions’
13 means the amount by which the amount contributed for
14 the taxable year to the account exceeds the amount allow-
15 able as a deduction under section 220 for such taxable
16 year. For purposes of this subsection, any contribution
17 which is distributed out of the medical savings account
18 and a distribution to which section 220(d)(2) applies shall
19 be treated as an amount not contributed.”

20 (d) TAX ON PROHIBITED TRANSACTIONS.—Section
21 4975 of such Code (relating to prohibited transactions)
22 is amended—

23 (1) by adding at the end of subsection (c) the
24 following new paragraph:

1 “(4) SPECIAL RULE FOR MEDICAL SAVINGS AC-
2 COUNTS.—An individual for whose benefit a medical
3 savings account is established shall be exempt from
4 the tax imposed by this section with respect to any
5 transaction concerning such account (which would
6 otherwise be taxable under this section) if, with re-
7 spect to such transaction, the account ceases to be
8 a medical savings account by reason of the applica-
9 tion of section 220(e)(2)(A) to such account.”, and

10 (2) by inserting “or a medical savings account
11 described in section 220(c)” in subsection (e)(1)
12 after “described in section 408(a)”.

13 (e) FAILURE TO PROVIDE REPORTS ON MEDICAL
14 SAVINGS ACCOUNTS.—Section 6693 of such Code (relat-
15 ing to failure to provide reports on individual retirement
16 account or annuities) is amended—

17 (1) by inserting “**OR ON MEDICAL SAVINGS**
18 **ACCOUNTS**” after “**ANNUITIES**” in the heading of
19 such section, and

20 (2) by adding at the end of subsection (a) the
21 following: “The person required by section 220(i) to
22 file a report regarding a medical savings account at
23 the time and in the manner required by such section
24 shall pay a penalty of \$50 for each failure unless it

1 is shown that such failure is due to reasonable
2 cause.”

3 (f) CLERICAL AMENDMENTS.—

4 (1) The table of sections for part VII of sub-
5 chapter B of chapter 1 of such Code is amended by
6 striking the item relating to section 220 and insert-
7 ing the following:

“Sec. 220. Medical savings accounts.

“Sec. 221. Cross reference.”

8 (2) The table of sections for chapter 43 of such
9 Code is amended by striking the item relating to sec-
10 tion 4973 and inserting the following:

“Sec. 4973. Tax on excess contributions to individual retirement
accounts, medical savings accounts, certain 403(b)
contracts, and certain individual retirement annu-
ities.”

11 (3) The table of sections for subchapter B of
12 chapter 68 of such Code is amended by inserting “or
13 on medical savings accounts” after “annuities” in
14 the item relating to section 6693.

15 (g) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to taxable years beginning after
17 December 31, 1992.

18 **SEC. 102. UNUSED AMOUNTS IN FLEXIBLE SPENDING AC-**
19 **COUNTS TRANSFERABLE TO MEDICAL SAV-**
20 **INGS ACCOUNTS.**

21 (a) IN GENERAL.—Subsection (d) of section 125 of
22 the Internal Revenue Code of 1986 (relating to cafeteria

1 plans) is amended by adding at the end thereof the follow-
2 ing new paragraph:

3 “(3) UNUSED AMOUNTS TRANSFERABLE TO
4 MEDICAL SAVINGS ACCOUNTS.—

5 “(A) IN GENERAL.—Subsection (a) shall
6 not fail to apply to a participant in a plan, and
7 a plan shall not fail to be treated as a cafeteria
8 plan, solely because under the plan amounts not
9 paid out as reimbursements under a flexible
10 spending arrangement for health and disability
11 for the benefit of an individual are contributed
12 to a medical savings account (as defined in sec-
13 tion 220(c)) for the benefit of such individual.

14 “(B) SPECIAL RULES.—

15 “(i) TIMING OF CONTRIBUTIONS.—
16 Contributions made under this paragraph
17 shall be made on the last day of the plan
18 year of the cafeteria plan.

19 “(ii) AVAILABILITY REQUIREMENT.—
20 Subparagraph (A) shall apply only if the
21 plan is available to at least 80 percent of
22 the employees of the employer. For pur-
23 poses of the preceding sentence, there shall
24 be excluded employees who are excluded
25 under section 414(q)(8) or who would be

1 so excluded if ‘30’ were substituted for
2 ‘17½’ in subparagraph (B) thereof.”

3 (b) TREATMENT OF AMOUNTS RECEIVED BY QUALI-
4 FIED CASH OR DEFERRED ARRANGEMENT.—

5 (1) Paragraph (2) of section 401(k) of such
6 Code is amended by striking “and” at the end of
7 subparagraph (C), by striking the period at the end
8 of subparagraph (D) and inserting “, and”, and by
9 adding at the end thereof the following new subpara-
10 graph:

11 “(E) which provides that, with respect to
12 amounts held by the trust which are attrib-
13 utable to contributions made to the trust pursu-
14 ant to section 125(d)(3)—

15 “(i) an employee’s right to such
16 amounts is nonforfeitable, and

17 “(ii) such amounts may be used only
18 to pay expenses (not compensated for by
19 insurance or otherwise) for the medical
20 care (as defined in section 213) of the em-
21 ployee, the spouse of the employee, or any
22 dependent (as defined in section 152) of
23 the employee.”

1 (2) Subsection (k) of section 401 of such Code
2 is amended by adding at the end thereof the follow-
3 ing new paragraph:

4 “(11) TREATMENT OF AMOUNTS RECEIVED
5 FROM MEDICAL SAVINGS ARRANGEMENTS.—Con-
6 tributions made to a trust by reason of section
7 125(d)(3) shall not be taken into account under
8 paragraph (3)(A)(ii), and subsection (l) shall not
9 apply to such contributions.”

10 (c) EFFECTIVE DATE.—The amendment made by
11 this section shall apply to taxable years beginning after
12 December 31, 1992.

13 **SEC. 103. DEDUCTION FOR AMOUNTS PAID FOR QUALIFIED**
14 **CATASTROPHIC COVERAGE HEALTH PLAN.**

15 (a) IN GENERAL.—Section 213 of the Internal Reve-
16 nue Code of 1986 (relating to medical, dental, etc., ex-
17 penses) is amended adding at the end thereof the following
18 new subsection:

19 “(g) FULL DEDUCTION FOR AMOUNTS PAID FOR
20 QUALIFIED CATASTROPHIC COVERAGE HEALTH
21 PLANS.—In the case of amounts paid for coverage under
22 a qualified catastrophic coverage health plan (as defined
23 in section 220(c))—

1 “(1) subsection (a) shall be applied without re-
2 gard to the limitation based on adjusted gross in-
3 come, and

4 “(2) such amounts shall not be taken into ac-
5 count in determining whether any other amounts are
6 allowable as a deduction under this section.”

7 (b) TECHNICAL AMENDMENT.—Paragraph (2) of
8 section 162(l) of such Code is amended by adding at the
9 end thereof the following new subparagraph:

10 “(C) QUALIFIED CATASTROPHIC COV-
11 ERAGE.—Paragraph (1) shall not apply to any
12 amount allowed as a deduction under section
13 213 for amounts paid for coverage under a
14 qualified catastrophic coverage health plan (as
15 defined in section 220(c)).”

16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to taxable years beginning after
18 December 31, 1992.

1 **TITLE II—TAX TREATMENT OF**
 2 **LONG-TERM CARE INSUR-**
 3 **ANCE AND PLANS**

4 **Subtitle A—Treatment of Long-**
 5 **Term Care Insurance**

6 **SEC. 201. QUALIFIED LONG-TERM CARE INSURANCE TREAT-**
 7 **ED AS ACCIDENT AND HEALTH INSURANCE**
 8 **FOR PURPOSES OF TAXATION OF LIFE INSUR-**
 9 **ANCE COMPANIES.**

10 (a) IN GENERAL.—Section 818 of the Internal Reve-
 11 nue Code of 1986 (relating to other definitions and special
 12 rules) is amended by adding at the end the following new
 13 subsection:

14 “(g) QUALIFIED LONG-TERM CARE INSURANCE
 15 TREATED AS ACCIDENT OR HEALTH INSURANCE.—For
 16 purposes of this part—

17 “(1) IN GENERAL.—Any reference to accident
 18 or health insurance shall be treated as including a
 19 reference to qualified long-term care insurance.

20 “(2) QUALIFIED LONG-TERM CARE INSUR-
 21 ANCE.—For purposes of this subsection—

22 “(A) IN GENERAL.—Subject to subpara-
 23 graphs (B) and (C), the term ‘qualified long-
 24 term care insurance’ means insurance under a
 25 policy or rider, which is issued by a qualified is-

1 suer, which meets standards at least as strin-
2 gent as those set forth in the January 1990
3 Long-Term Care Insurance Model Regulation
4 of the National Association of Insurance Com-
5 missioners, and which is certified by the Sec-
6 retary of Health and Human Services (in ac-
7 cordance with procedures similar to the proce-
8 dures prescribed in section 1882 of the Social
9 Security Act (42 U.S.C. 1385ss) used in the
10 certification of medicare supplemental policies
11 (as defined in subsection (g)(1) of such sec-
12 tion)) to be advertised, marketed, offered, or
13 designed to provide coverage—

14 “(i) for not less than 12 consecutive
15 months for each covered person who has
16 attained age 50,

17 “(ii) on an expense incurred, indem-
18 nity, or prepaid basis,

19 “(iii) for 1 or more medically nec-
20 essary, diagnostic services, preventive serv-
21 ices, therapeutic services, rehabilitation
22 services, maintenance services, or personal
23 care services, and

24 “(iv) provided in a setting other than
25 an acute care unit of a hospital.

1 The requirement of clause (iv) shall be met only
2 if at least 1 of the settings in which such cov-
3 erage is provided is the patient's home.

4 “(B) COVERAGE SPECIFICALLY EX-
5 CLUDED.—Such term does not include any in-
6 surance under any policy or rider which is of-
7 fered primarily to provide any combination of
8 the following kinds of coverage:

9 “(i) Basic Medicare supplement cov-
10 erage.

11 “(ii) Basic hospital-based acute care
12 expense coverage.

13 “(iii) Basic medical-surgical expense
14 coverage.

15 “(iv) Hospital confinement indemnity
16 coverage.

17 “(v) Major medical expense coverage.

18 “(vi) Disability income protection cov-
19 erage.

20 “(vii) Accident only coverage.

21 “(viii) Specified disease coverage.

22 “(ix) Specified accident coverage.

23 “(x) Limited benefit health coverage.

“(C) QUALIFIED ISSUER.—For purposes of subparagraph (A), the term ‘qualified issuer’ means any of the following:

“(i) Private insurance company.

“(ii) Fraternal benefit society.

“(iii) Nonprofit health corporation.

“(iv) Nonprofit hospital corporation.

“(v) Nonprofit medical service corporation.

“(vi) Prepaid health plan.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1992.

SEC. 202. QUALIFIED LONG-TERM CARE INSURANCE TREATED AS ACCIDENT AND HEALTH INSURANCE FOR PURPOSES OF EXCLUSION FOR BENEFITS RECEIVED UNDER SUCH INSURANCE AND FOR EMPLOYER CONTRIBUTIONS FOR SUCH INSURANCE.

(a) IN GENERAL.—Section 105 of the Internal Revenue Code of 1986 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

1 “(j) SPECIAL RULES RELATING TO QUALIFIED
2 LONG-TERM CARE INSURANCE.—For purposes of section
3 104, this section, and section 106—

4 “(1) BENEFITS TREATED AS PAYABLE FOR
5 SICKNESS, ETC.—Any benefit received through quali-
6 fied long-term care insurance (as defined in section
7 818(g)) shall be treated as received for personal in-
8 juries or sickness.

9 “(2) EXPENSES FOR WHICH REIMBURSEMENT
10 PROVIDED UNDER QUALIFIED LONG-TERM CARE IN-
11 SURANCE TREATED AS INCURRED FOR MEDICAL
12 CARE.—Expenses incurred by a taxpayer for which
13 reimbursement is paid through qualified long-term
14 care insurance (as so defined) shall be treated for
15 purposes of subsection (b) as incurred for medical
16 care (as defined in section 213(d)).

17 “(3) REFERENCES TO ACCIDENT AND HEALTH
18 PLANS.—Any reference to an accident or health plan
19 shall be treated as including a reference to a plan
20 providing qualified long-term care insurance.”

21 (b) EFFECTIVE DATE.—The amendment made by
22 subsection (a) shall apply to taxable years beginning after
23 December 31, 1992.

1 **SEC. 203. EXCLUSION FROM GROSS INCOME FOR AMOUNTS**
 2 **WITHDRAWN FROM INDIVIDUAL RETIRE-**
 3 **MENT PLANS OR 401(k) PLANS FOR QUALI-**
 4 **FIED LONG-TERM CARE INSURANCE.**

5 (a) IN GENERAL.—Part III of subchapter B of chap-
 6 ter 1 of the Internal Revenue Code of 1986 (relating to
 7 items specifically excluded from gross income) is amended
 8 by redesignating section 136 as section 137 and by insert-
 9 ing after section 135 the following new section:

10 **“SEC. 136. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT**
 11 **ACCOUNTS AND SECTION 401(k) PLANS FOR**
 12 **QUALIFIED LONG-TERM CARE INSURANCE.**

13 “(a) GENERAL RULE.—The amount includible in the
 14 gross income of an individual for the taxable year by rea-
 15 son of qualified distributions during such taxable year
 16 shall not exceed the excess of—

17 “(1) the amount which would (but for this sec-
 18 tion) be so includible by reason of such distributions,
 19 over

20 “(2) the aggregate premiums paid by such indi-
 21 vidual during such taxable year for any policy of
 22 qualified long-term care insurance (as defined in sec-
 23 tion 818(g)) for the benefit of such individual or the
 24 spouse of such individual.

25 “(b) QUALIFIED DISTRIBUTION.—For purposes of
 26 this section, the term ‘qualified distribution’ means any

1 distribution to an individual from an individual retirement
2 account or a section 401(k) plan if such individual has
3 attained age 59½ on or before the date of the distribution
4 (and, in the case of a distribution used to pay premiums
5 for the benefit of the spouse of such individual, such
6 spouse has attained age 59½ on or before the date of the
7 distribution).

8 “(c) DEFINITIONS.—For purposes of this section—

9 “(1) INDIVIDUAL RETIREMENT ACCOUNT.—The
10 term ‘individual retirement account’ has the mean-
11 ing given such term by section 408(a).

12 “(2) SECTION 401(k) PLAN.—The term ‘section
13 401(k) plan’ means any employer plan which meets
14 the requirements of section 401(a) and which in-
15 cludes a qualified cash or deferred arrangement (as
16 defined in section 401(k)).

17 “(d) SPECIAL RULES FOR SECTION 401(k) PLANS.—

18 “(1) WITHDRAWALS CANNOT EXCEED ELEC-
19 TIVE CONTRIBUTIONS UNDER QUALIFIED CASH OR
20 DEFERRED ARRANGEMENT.—This section shall not
21 apply to any distribution from a section 401(k) plan
22 to the extent the aggregate amount of such distribu-
23 tions for the use described in subsection (a) exceeds
24 the aggregate employer contributions made pursuant
25 to the employee’s election under section 401(k)(2).

11 (1) Section 401(k) of such Code is amended by
12 adding at the end the following new paragraph:

“For provision permitting tax-free withdrawals for payment of long-term care premiums, see section 136.”

14 (2) Section 408(d) of such Code is amended by
15 adding at the end the following new paragraph:

“For provision permitting tax-free withdrawals from individual retirement accounts for payment of long-term care premiums, see section 136.”

(3) The table of sections for such part III is amended by striking the last item and inserting the following new items:

“Sec. 136. Distributions from individual retirement accounts and section 401(k) plans for qualified long-term care insurance.

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1 (c) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to taxable years beginning after
3 December 31, 1992.

4 **SEC. 204. EXCHANGE OF LIFE INSURANCE POLICY FOR**
5 **QUALIFIED LONG-TERM CARE POLICY NOT**
6 **TAXABLE.**

7 (a) IN GENERAL.—Subsection (a) of section 1035 of
8 the Internal Revenue Code of 1986 (relating to certain
9 exchanges of insurance policies) is amended by striking
10 the period at the end of paragraph (3) and inserting “;
11 or” and by adding at the end the following new paragraph:

12 “(4) in the case of an individual who has at-
13 tained age 59½, a contract of life insurance or a
14 contract of endowment insurance or an annuity con-
15 tract for a contract of qualified long-term care insur-
16 ance (as defined in section 818(g)) for the benefit of
17 such individual or the spouse of such individual if
18 such spouse has attained age 59½ on or before the
19 date of the exchange.”

20 (b) EFFECTIVE DATE.—The amendment made by
21 this section shall apply to taxable years beginning after
22 December 31, 1992.

1 **Subtitle B—Employer Funding of**
2 **Medical Benefits**

3 **SEC. 211. MEDICAL BENEFITS FOR RETIRED EMPLOYEES**
4 **AND THEIR SPOUSES AND DEPENDENTS.**

5 (a) IN GENERAL.—Section 401(h) of the Internal
6 Revenue Code of 1986 (relating to medical, etc., benefits
7 for retired employees and their spouses and dependents)
8 is amended to read as follows:

9 “(h) RETIREE HEALTH ACCOUNTS.—

10 “(1) GENERAL RULE.—Under regulations pre-
11 scribed by the Secretary, a defined benefit plan may
12 establish and maintain a separate health benefits ac-
13 count for the payment of medical benefits of retired
14 employees and their spouses and dependents.

15 “(2) SEPARATE ACCOUNTING REQUIRED.—An
16 employer establishing a health benefits account shall
17 maintain separate accounts within the health bene-
18 fits account for funded reserve accounts established
19 under section 420A.

20 “(3) USE OF ASSETS.—Subject to the provi-
21 sions of part III of this subchapter, the corpus or in-
22 come of a health benefits account shall not be used
23 for, or diverted to, any purpose other than providing
24 medical benefits to retired employees and their
25 spouses and dependents.

1 “(4) KEY EMPLOYEES.—

2 “(A) IN GENERAL.—In the case of an em-
3 ployee who is a key employee—

4 “(i) a separate account shall be estab-
5 lished and maintained for medical benefits
6 payable to such employee (and the employ-
7 ee’s spouse or dependents), and

8 “(ii) medical benefits of such em-
9 ployee, spouse, or dependents which are at-
10 tributable to plan years beginning after
11 March 31, 1984, for which the employee is
12 a key employee may be payable only from
13 such account.

14 “(B) KEY EMPLOYEE.—For purposes of
15 subparagraph (A), the term ‘key employee’
16 means any employee who, at any time during
17 the plan year or any preceding plan year during
18 which contributions were made on behalf of
19 such employee, is or was a key employee (as de-
20 fined in section 416(i)).

21 “(5) APPLICABLE RULES.—For rules applicable
22 to health benefits accounts, see subpart F of this
23 part (sec. 420A et seq.).”

24 (b) CONFORMING AMENDMENT.—Section 415(l)(2)
25 of such Code (relating to treatment of certain medical ben-

1 efits) is amended by inserting “by reason of section
2 401(h)(4)” after “dependents” in subparagraph (B).

3 (c) EFFECTIVE DATE.—

4 (1) IN GENERAL.—Except as provided in para-
5 graph (2), the amendments made by this section
6 shall apply to years beginning after December 31,
7 1992.

8 (2) TRANSITION RULE.—In the case of—

9 (A) a plan other than a defined benefit
10 plan, or

11 (B) a defined benefit plan which elects, at
12 such time and in such manner as the Secretary
13 of the Treasury or his delegate may prescribe,
14 to have this paragraph apply,

15 which on or before the date of the enactment of this
16 Act established an account to which section 401(h)
17 of the Internal Revenue Code of 1986 (as in effect
18 before the amendments made by this section) ap-
19 plied (and which is in existence on such date), the
20 amendments made by this section shall not apply to
21 such account.

22 **SEC. 212. TREATMENT OF HEALTH BENEFITS ACCOUNTS.**

23 (a) IN GENERAL.—Part I of subchapter D of chapter
24 1 of the Internal Revenue Code of 1986 is amended by
25 adding at the end the following new subpart:

1 **“Subpart F—Treatment of Health Benefits Accounts**

“Sec. 420A. Deduction for employer contributions to health benefits accounts.

“Sec. 420B. Funded reserve account.

“Sec. 420C. Definitions; special rules.

2 **“SEC. 420A. DEDUCTION FOR EMPLOYER CONTRIBUTIONS**
 3 **TO HEALTH BENEFITS ACCOUNTS.**

4 “(a) GENERAL RULE.—Amounts paid by an employer to a defined benefit plan which are allocated to a health benefits account—

7 “(1) shall not be allowed as a deduction under this chapter, but

9 “(2) if they would otherwise be deductible, shall be allowed as a deduction under this section for the taxable year in which paid.

12 “(b) LIMITATION.—The amount of the deduction allowable under subsection (a)(2) for any taxable year shall not exceed the health benefits account’s qualified cost for the taxable year.

16 “(c) QUALIFIED COST.—For purposes of this section—

18 “(1) IN GENERAL.—The term ‘qualified cost’ means, with respect to any taxable year, the sum of—

21 “(A) the qualified direct cost for such taxable year, plus

1 “(B) subject to the limitation of section
2 420B(b), any addition to the funded reserve ac-
3 count established under section 420B.

4 “(2) QUALIFIED DIRECT COST.—

5 “(A) IN GENERAL.—The term ‘qualified
6 direct cost’ means, with respect to any taxable
7 year, the aggregate amount (including adminis-
8 trative expenses) which would have been allow-
9 able as a deduction to the employer with re-
10 spect to the qualified section 401(h) medical
11 benefits provided through the health benefits
12 account during the taxable year if—

13 “(i) such benefits were provided di-
14 rectly by the employer, and

15 “(ii) the employer used the cash re-
16 ceipts and disbursements method of ac-
17 counting.

18 “(B) TIME WHEN BENEFITS PROVIDED.—

19 For purposes of subparagraph (A), a benefit
20 shall be treated as provided when such benefit
21 would be includible in the gross income of the
22 employee if provided directly by the employer
23 (or would be so includible but for any provision
24 of this chapter excluding such benefit from
25 gross income).

1 **“SEC. 420B. FUNDED RESERVE ACCOUNT.**

2 “(a) GENERAL RULE.—For purposes of this subpart
3 and section 401(h), the term ‘funded reserve account’
4 means an account within a health benefits account—

5 “(1) to which contributions paid or accrued to
6 a defined benefit plan are allocated to provide a re-
7 serve for the payment of qualified section 401(h)
8 medical benefits of employees and their spouses and
9 dependents,

10 “(2) with respect to which the only contribu-
11 tions allocated are employer contributions, and

12 “(3) with respect to which—

13 “(A) the vesting requirements of sub-
14 section (c),

15 “(B) the portability requirements of sub-
16 section (d), and

17 “(C) the availability requirements of sub-
18 section (e),

19 are met.

20 “(b) LIMITATION ON ALLOCATION TO ACCOUNT.—

21 “(1) IN GENERAL.—No amount may be allo-
22 cated to a funded reserve account (and taken into
23 account under section 420A(c)(1)(B)) to the extent
24 such addition results in the amount allocated to such
25 account exceeding the account limit.

1 “(2) ACCOUNT LIMIT.—The account limit for
2 any taxable year is an amount equal to 125 percent
3 of the termination liability of the account as of the
4 close of the last plan year ending with or within the
5 taxable year.

6 “(3) TERMINATION LIABILITY.—For purposes
7 of this section—

8 “(A) IN GENERAL.—The term ‘termination
9 liability’ means the present value of the quali-
10 fied section 401(h) medical benefits—

11 “(i) which are to be provided to em-
12 ployees (and their spouses and depend-
13 ents), and

14 “(ii) any portion of which is to be pro-
15 vided through a funded reserve account.

16 “(B) DETERMINATIONS.—The termination
17 liability under subparagraph (A) shall be deter-
18 mined—

19 “(i) on the basis of actuarial assump-
20 tions which are used in determining the
21 full-funding limitation of the plan under
22 section 412(c)(7),

23 “(ii) as if the benefits under the plan
24 commenced at Social Security retirement
25 age, and

1 “(iii) by not taking into account any
2 portion of the maximum annual benefit
3 under the plan for—

4 “(I) benefits (other than post-re-
5 tirement long-term health care bene-
6 fits) in excess of \$1,500, or

7 “(II) post-retirement long-term
8 health care benefits in excess of
9 \$1,500.

10 “(C) ADJUSTMENTS TO ACCOUNT.—The
11 amount in the account shall be adjusted at such
12 time and in such manner as the Secretary may
13 prescribe to take into account income, gains,
14 deductions, or losses which are properly alloca-
15 ble to amounts in the account.

16 “(D) ACTUARIAL ADJUSTMENT.—For pur-
17 poses of determining termination liability, the
18 benefits provided to any participant under the
19 plan shall be actuarially adjusted to reflect any
20 commencement of benefits before or after Social
21 Security retirement age.

22 “(E) EMPLOYEE.—For purposes of this
23 paragraph, the term ‘employee’ does not include
24 a former employee.

1 “(F) COST-OF-LIVING ADJUSTMENT.—In
2 the case of years beginning after 1995, the
3 \$1,500 amounts in subparagraph (B) shall be
4 adjusted annually at the same time and in the
5 same manner as under section 415(d).

6 “(c) VESTING REQUIREMENTS.—

7 “(1) IN GENERAL.—The requirements of this
8 subsection are met if the requirements of either sub-
9 paragraph (A) or (B) of section 411(a)(2) are met
10 with respect to the accrued qualified section 401(h)
11 medical benefits derived from amounts which are al-
12 located to the funded reserve account.

13 “(2) UNIFORM RATE OF ACCRUAL OF BENE-
14 FITS.—

15 “(A) IN GENERAL.—Except as provided in
16 this paragraph, a plan shall not be treated as
17 meeting the requirements of this subsection un-
18 less the rate at which benefits accrue during a
19 plan year is the same for all participants.

20 “(B) SPECIAL RULES FOR CERTAIN INDIV-
21 IDUALS AGE 55 AND OVER.—A plan shall not
22 be treated as failing to meet the requirements
23 of this subsection if the plan provides that an
24 employee who as of the close of the plan year
25 in which he attains age 55 has accrued less

1 than 30 percent of the maximum amount of
2 benefits which may be accrued under the plan
3 may accrue benefits during succeeding plan
4 years at a greater rate than the rate for other
5 employees (but not in excess of 125 percent of
6 such other rate).

7 “(C) MINIMUM HOURS OF SERVICE.—For
8 purposes of subparagraph (A), an employee
9 shall not be treated as a participant for any
10 plan year unless such individual completes more
11 than 500 hours of service during such year.

12 “(3) CERTAIN RULES MADE APPLICABLE.—Ex-
13 cept to the extent inconsistent with the provisions of
14 this subpart, the rules of section 411 shall apply for
15 purposes of this subsection.

16 “(d) PORTABILITY REQUIREMENTS.—

17 “(1) IN GENERAL.—Except as provided in para-
18 graph (2), the requirements of this subsection are
19 met if, in accordance with procedures determined by
20 the Secretary, the plan provides that—

21 “(A) except as provided in regulations, the
22 plan shall transfer, within 120 days after an
23 employee separates from service with the em-
24 ployer or after the termination of the plan, the
25 present value of the nonforfeitable accrued

1 qualified section 401(h) medical benefits of the
2 employee attributable to amounts which are al-
3 located to the funded reserve account to—

4 “(i) a plan which is maintained by an
5 employer of such employee and which
6 maintains a health benefits account, or

7 “(ii) if the employer does not main-
8 tain a plan described in clause (i), an indi-
9 vidual retirement account established for
10 the benefit of such employee, and

11 “(B) the plan accepts transfers under sub-
12 paragraph (A) from another plan or individual
13 retirement account.

14 “(2) NO TRANSFERS AFTER EMPLOYEE IS DIS-
15 ABLED OR ATTAINS RETIREMENT AGE.—Except in
16 the case of a termination of a plan, a plan shall not
17 meet the requirements of this subsection if it per-
18 mits the transfer of a benefit after—

19 “(A) an employee has attained Social Se-
20 curity retirement age, or

21 “(B) an employee has become disabled
22 (within the meaning of section 72(m)(7)).

23 “(3) INCLUSION IN INCOME WHERE MORE
24 THAN 1 ACCOUNT.—

25 “(A) IN GENERAL.—If—

1 “(i) an individual is a participant or
2 beneficiary under 2 or more plans main-
3 taining a funded reserve account or indi-
4 vidual retirement account to which assets
5 were transferred from such a plan, and

6 “(ii) such individual does not (within
7 a reasonable period) consolidate the
8 present value of the individual’s nonforfeit-
9 able accrued benefit in all such plans and
10 the assets so transferred to all such ac-
11 counts into 1 such plan or into 1 such ac-
12 count,

13 then an amount equal to the sum of the present
14 value of such benefits and the fair market value
15 of such assets shall be treated as distributed in
16 cash to such individual at the close of the plan
17 year for the plan or account involved and such
18 distribution shall be included in gross income.

19 “(B) SPECIAL RULES.—

20 “(i) EMPLOYEE MUST CONSOLIDATE
21 INTO PLAN OF CURRENT EMPLOYER.—In
22 the case of an employee who is employed
23 by an employer maintaining a plan de-
24 scribed in subparagraph (A)(i), a consoli-
25 dation satisfies subparagraph (A) only if

1 such consolidation is into such a plan
2 maintained by such employer.

3 “(ii) MORE THAN 1 CURRENT EM-
4 PLOYER.—If an individual is a participant
5 in more than 1 plan described in subpara-
6 graph (A)(i) by reason of being currently
7 employed by more than 1 employer, such
8 plans shall be treated as 1 plan for pur-
9 poses of subparagraph (A).

10 “(iii) EMPLOYEE WITH NO CURRENT
11 EMPLOYER MAINTAINING PLAN.—In the
12 case of an employee who is currently not
13 employed by an employer maintaining a
14 plan described in subparagraph (A)(i), a
15 consolidation satisfies subparagraph (A)
16 only if such consolidation is into—

17 “(I) a plan described in subpara-
18 graph (A)(i) maintained by his most
19 recent employer maintaining such
20 plan, or

21 “(II) an individual retirement ac-
22 count of the individual.

23 “(C) AMOUNT TRANSFERRED NOT INCLUD-
24 IBLE IN INCOME.—No amount shall be includ-
25 ible in gross income by reason of any transfer

1 which is part of a consolidation required under
2 this paragraph.

3 “(e) RETIRED EMPLOYEES NOT COVERED BY
4 HEALTH BENEFITS ACCOUNT MAY ELECT COVERAGE.—

5 “(1) IN GENERAL.—The requirements of this
6 subsection are met if the plan provides that a former
7 employee who—

8 “(A) is in pay status under the plan, but

9 “(B) is not eligible to receive all or any
10 portion of qualified section 401(h) medical ben-
11 efits provided for any period through the fund-
12 ed reserve account,

13 is entitled to elect such benefits for himself or his
14 spouse and dependents. A plan shall not be treated
15 as failing to meet the requirements of this sub-
16 section if an employee is required to pay a premium
17 for such benefits as long as such premium does not
18 exceed 102 percent of applicable premium for the
19 period such benefits are provided.

20 “(2) APPLICABLE PREMIUM.—For purposes of
21 paragraph (1), the applicable premium for any pe-
22 riod shall be determined in the same manner as
23 under section 4980B(f)(4).

1 **“SEC. 420C. DEFINITIONS; SPECIAL RULES.**

2 “(a) QUALIFIED SECTION 401(h) MEDICAL BENE-
3 FITS.—For purposes of this subpart, the term ‘qualified
4 section 401(h) medical benefits’ means benefits—

5 “(1) which are—

6 “(A) benefits for sickness, accident, hos-
7 pitalization, and medical expenses of former
8 employees who are in pay status under the plan
9 (and their spouse or dependents) after the
10 former employee—

11 “(i) has attained Social Security re-
12 tirement age, or

13 “(ii) is disabled (within the meaning
14 of section 72(m)(7)), or

15 “(B) post-retirement long-term health care
16 benefits, and

17 “(2) which are provided through 1 or more of
18 the following:

19 “(A) insurance acquired by the plan, or

20 “(B) self-insurance by the employer or the
21 plan.

22 “(b) POST-RETIREMENT LONG-TERM HEALTH
23 CARE.—For purposes of this subpart—

24 “(1) IN GENERAL.—The term ‘post-retirement
25 long-term health care’ means long-term health care
26 benefits provided to a former employee (or the

1 spouse of the former employee) who is in pay status
2 under the plan after the former employee—

3 “(A) has attained Social Security retire-
4 ment age, or

5 “(B) is disabled (within the meaning of
6 section 72(m)(7)).

7 “(2) SPOUSE OF DECEASED EMPLOYEE.—For
8 purposes of paragraph (1), the spouse of a deceased
9 employee shall be treated—

10 “(A) as a former employee, and

11 “(B) as satisfying the requirements of
12 paragraph (1) if such spouse was receiving ben-
13 efits immediately before the death of the em-
14 ployee.

15 “(3) LONG-TERM HEALTH CARE BENEFIT.—

16 “(A) IN GENERAL.—The term ‘long-term
17 health care benefit’ means a benefit which con-
18 sists of the providing by a qualified provider in
19 a qualified facility of necessary diagnostic, pre-
20 ventive, therapeutic, rehabilitative, and personal
21 care services, required by a chronically ill indi-
22 vidual.

23 “(B) CERTAIN ITEMS NOT INCLUDED.—

24 The term ‘long-term health care benefits’ does
25 not include basic medicare supplement cov-

1 erage, basic hospital expense coverage, basic
2 medical-surgical expense coverage, hospital con-
3 finement indemnity coverage, major medical ex-
4 pense coverage, disability income protection cov-
5 erage, accident only coverage, specified disease
6 or specified accident coverage, or limited benefit
7 health coverage.

8 “(4) QUALIFIED FACILITY.—The term ‘quali-
9 fied facility’ means—

10 “(A) a rehabilitative, hospice, or adult day
11 care facility, including a hospital, retirement
12 home, skilled nursing facility (within the mean-
13 ing of section 1919(a) of the Social Security
14 Act), or other similar facility determined by the
15 plan administrator, or

16 “(B) a home where the chronically ill indi-
17 vidual resides.

18 “(5) CHRONICALLY ILL INDIVIDUAL.—The term
19 ‘chronically ill individual’ means an individual whose
20 disability is such that the individual has been cer-
21 tified as requiring assistance with daily living (as de-
22 fined by the plan administrator) for a period of at
23 least 90 days.

24 “(6) QUALIFIED PROVIDER.—The term ‘quali-
25 fied provider’ means a medical practitioner licensed

1 under State law, registered nurse, licensed vocational
2 nurse, qualified therapist, or trained home health
3 aide (or any organization employing such providers),
4 but does not include a relative or other person who
5 ordinarily resides in the home where the chronically
6 ill individual resides.

7 “(c) HEALTH BENEFITS ACCOUNT.—For purposes of
8 this subpart, the term ‘health benefits account’ means an
9 account established and maintained under section 401(h).

10 “(d) SOCIAL SECURITY RETIREMENT AGE.—For
11 purposes of this subpart, the term ‘Social Security retire-
12 ment age’ has the meaning given such term by section
13 415(b)(8).”

14 (b) INDIVIDUAL RETIREMENT ACCOUNTS.—

15 (1) IN GENERAL.—Section 408 of such Code is
16 amended by redesignating subsection (p) as sub-
17 section (q) and by inserting after subsection (o) the
18 following new subsection:

19 “(p) SPECIAL RULES FOR FUNDED RESERVE AC-
20 COUNTS.—

21 “(1) IN GENERAL.—A trust shall not be treated
22 as an individual retirement account under subsection
23 (a) unless the trust instrument provides that the
24 trust will accept transfers of assets as provided in
25 section 420B(d)(1).

1 “(2) ACCOUNTING.—The trustee of an individ-
2 ual retirement account shall maintain separate ac-
3 counting for assets transferred to the account under
4 section 420B(d)(1) (and any income allocable there-
5 to).”

6 (2) PENALTY FOR EARLY DISTRIBUTIONS.—
7 Section 72(t) of such Code (relating to 10-percent
8 additional tax on early distributions) is amended by
9 adding at the end the following new paragraph:

10 “(6) EARLY DISTRIBUTION OF MEDICAL BENE-
11 FITS.—If—

12 “(A) a taxpayer receives a distribution of
13 amounts transferred to an individual retirement
14 account under section 420B(d)(1) (or any in-
15 come or gain allocable thereto), and

16 “(B) such distribution—

17 “(i) is made before the individual at-
18 tains Social Security retirement age (with-
19 in the meaning of section 415(b)(8)) or be-
20 comes disabled (within the meaning of sub-
21 section (m)(7)), or

22 “(ii) exceeds the amount of qualified
23 section 401(h) medical expenses of the tax-
24 payer, his spouse, or dependents for the
25 taxable year,

1 then paragraph (1) shall apply to such distribution
2 or such excess, except that ‘50 percent’ shall be sub-
3 stituted for ‘10 percent’. Paragraph (2) shall not
4 apply to a distribution to which this paragraph ap-
5 plies.”

6 (c) EXCISE TAX ON ALLOCATED ASSETS NOT USED
7 TO PROVIDE RETIREE HEALTH BENEFITS.—Section
8 4980 of such Code (relating to tax on reversion of quali-
9 fied plan assets to employers) is amended by adding at
10 the end the following new subsection:

11 “(e) ASSETS ALLOCATED TO RETIREE HEALTH BEN-
12 EFITS ACCOUNTS.—In the case of a plan which establishes
13 a health benefits account described in section 401(h), if—

14 “(1) amounts are allocated to a funded reserve
15 account under section 420B, and

16 “(2) any amount in such account is paid or dis-
17 tributed other than to pay for qualified section
18 401(h) medical benefits (as defined in section
19 420C(a)) provided through such account,

20 the amount so paid or distributed shall be treated as an
21 employer reversion for purposes of this section, except that
22 subsection (a) shall be applied by substituting ‘100 per-
23 cent’ for ‘25 percent’.”

24 (d) CONFORMING AMENDMENTS.—

1 (1) Section 419(e) of such Code (defining wel-
2 fare benefit fund) is amended by adding at the end
3 the following new paragraph:

4 “(5) HEALTH BENEFITS ACCOUNTS.—The term
5 ‘welfare benefits fund’ does not include any health
6 benefits account established under section 401(h).”

7 (2) The table of subparts for part I of sub-
8 chapter D of chapter 1 of such Code is amended by
9 adding at the end the following new item:

 “Subpart F. Treatment of health benefit accounts.”

10 (e) EFFECTIVE DATE.—

11 (1) IN GENERAL.—Except as provided in para-
12 graph (2), the amendments made by this section
13 shall apply to contributions after December 31,
14 1992.

15 (2) INDIVIDUAL RETIREMENT ACCOUNTS.—The
16 amendments made by subsection (b) shall apply to
17 accounts established after December 31, 1992.

18 **Subtitle C—Reverse Mortgage**
19 **Insurance for Older Americans**

20 **SEC. 221. MAXIMUM AMOUNT INSURED.**

21 Section 255(g) of the National Housing Act (12
22 U.S.C. 1715z–20(g)) is amended by striking the third sen-
23 tence and inserting the following new sentence: “In no
24 case may the benefits of insurance under this section ex-
25 ceed the greater of 95 percent of the median 1-family

1 house price in the United States or 95 percent of the me-
 2 dian 1-family house price in the area, as determined by
 3 the Secretary.”

4 **Subtitle D—Income Tax Credits**

5 **SEC. 231. REFUNDABLE CREDIT FOR CUSTODIAL CARE OF** 6 **CERTAIN DEPENDENTS IN TAXPAYER’S** 7 **HOME.**

8 (a) IN GENERAL.—Subpart C of part IV of sub-
 9 chapter A of chapter 1 of the Internal Revenue Code of
 10 1986 (relating to refundable credits) is amended by redес-
 11 ignating section 35 as section 37 and by inserting after
 12 section 34 the following new section:

13 **“SEC. 35. CREDIT FOR TAXPAYERS WITH CERTAIN PERSONS** 14 **REQUIRING CUSTODIAL CARE IN THEIR** 15 **HOUSEHOLDS.**

16 “(a) ALLOWANCE OF CREDIT.—In the case of an in-
 17 dividual who maintains a household which includes as a
 18 member one or more qualified persons, there shall be al-
 19 lowed as a credit against the tax imposed by this chapter
 20 for the taxable year an amount equal to \$2,000 for each
 21 such person.

22 “(b) DEFINITIONS.—For purposes of this section—

23 “(1) QUALIFIED PERSON.—The term ‘qualified
 24 person’ means any individual—

1 “(A) who is a parent, grandparent, de-
2 pendent (as defined in section 152), or spouse
3 of the taxpayer,

4 “(B) who has been certified by a physician
5 as—

6 “(i) being unable to perform (without
7 substantial assistance from another indi-
8 vidual) at least 2 activities of daily living
9 (as defined in paragraph (2)), or

10 “(ii) having a similar level of disabil-
11 ity due to cognitive impairment, and

12 “(C) who has as his principal place of
13 abode for more than half of the taxable year the
14 home of the taxpayer.

15 “(2) ACTIVITIES OF DAILY LIVING.—For pur-
16 poses of paragraph (1), each of the following is an
17 activity of daily living:

18 “(A) BATHING.—The overall complex be-
19 havior of getting water and cleansing the whole
20 body, including turning on the water for a bath,
21 shower, or sponge bath, getting to, in, and out
22 of a tub or shower, and washing and drying
23 oneself.

1 “(B) DRESSING.—The overall complex be-
2 havior of getting clothes from closets and draw-
3 ers and then getting dressed.

4 “(C) TOILETING.—The act of going to the
5 toilet room for bowel and bladder function,
6 transferring on and off the toilet, cleaning after
7 elimination, and arranging clothes.

8 “(D) TRANSFER.—The process of getting
9 in and out of bed or in and out of a chair or
10 wheelchair.

11 “(E) EATING.—The process of getting
12 food from a plate or its equivalent into the
13 mouth.

14 “(3) PHYSICIAN.—The term ‘physician’ means
15 a doctor of medicine or osteopathy legally authorized
16 to practice medicine or surgery in the jurisdiction in
17 which he makes the determination under paragraph
18 (1).

19 “(d) SPECIAL RULES.—For purposes of this sec-
20 tion—

21 “(1) MAINTAINING A HOUSEHOLD.—An individ-
22 ual shall be treated as maintaining a household for
23 any period if over half the cost of maintaining the
24 household for such period is furnished by such indi-

1 vidual (or, if such individual is married during such
2 period, by such individual and his spouse).

3 “(2) MARRIED COUPLES MUST FILE JOINT RE-
4 TURN.—If the taxpayer is married at the close of
5 the taxable year, the credit under subsection (a)
6 shall be allowed only if the taxpayer and his spouse
7 file a joint return for the taxable year.

8 “(3) MARITAL STATUS.—An individual legally
9 separated from his spouse under a decree of divorce
10 or separate maintenance shall not be considered as
11 married.

12 “(4) CERTAIN MARRIED INDIVIDUALS LIVING
13 APART.—If—

14 “(A) an individual who is married and who
15 files a separate return—

16 “(i) maintains a household which in-
17 cludes as a member one or more qualified
18 persons, and

19 “(ii) furnishes over half of the cost of
20 maintaining such household during such
21 taxable year, and

22 “(B) during the last 6 months of such tax-
23 able year such individual’s spouse is not a mem-
24 ber of such household,

25 such individual shall not be considered as married.

1 “(e) REGULATIONS.—The Secretary shall prescribe
 2 such regulations as may be necessary to carry out the pur-
 3 poses of this section.”

4 (b) CLERICAL AMENDMENT.—The table of sections
 5 for subpart C of part IV of subchapter A of chapter 1
 6 of such Code is amended by striking the item relating to
 7 section 35 and inserting the following:

“Sec. 35. Credit for taxpayers with certain persons requiring cus-
 todial care in their households.”

8 (c) EFFECTIVE DATE.—The amendments made by
 9 this section shall apply to taxable years beginning after
 10 December 31, 1992.

11 **SEC. 232. CREDIT FOR EXPENSES FOR LONG-TERM CARE**
 12 **SERVICES PROVIDED TO CERTAIN INDE-**
 13 **PENDENT PERSONS REQUIRING SUCH CARE.**

14 (a) GENERAL RULE.—Subpart C of part IV of sub-
 15 chapter A of chapter 1 of the Internal Revenue Code of
 16 1986 (relating to refundable credits) is amended by insert-
 17 ing after section 35 the following new section:

18 **“SEC. 36. CREDIT FOR EXPENSES FOR LONG-TERM CARE**
 19 **SERVICES PROVIDED TO CERTAIN INDE-**
 20 **PENDENT PERSONS REQUIRING SUCH CARE.**

21 “(a) GENERAL RULE.—In the case of an individual,
 22 there shall be allowed as a credit against the tax imposed
 23 by this subtitle for the taxable year an amount equal to

1 25 percent of the qualified long-term care expenses paid
2 during such taxable year.

3 “(b) MAXIMUM CREDIT.—

4 “(1) IN GENERAL.—The credit allowed by sub-
5 section (a) for any taxable year shall not exceed
6 \$2,000 with respect to each independent qualified
7 person.

8 “(2) PHASEOUT OF CREDIT FOR TAXPAYERS
9 WITH INCOMES EXCEEDING 150 PERCENT OF THE
10 POVERTY LEVEL.—If the adjusted gross income of
11 the taxpayer for the taxable year exceeds the base
12 amount, the \$2,000 amount in paragraph (1) shall
13 be reduced (but not below zero) by an amount which
14 bears the same ratio to \$2,000 as—

15 “(A) the excess of the taxpayer’s adjusted
16 gross income for the taxable year over the base
17 amount, bears to

18 “(B) \$10,000.

19 For purposes of the preceding sentence, the base
20 amount is 150 percent of the poverty level applicable
21 to the taxpayer.

22 “(c) DEFINITIONS.—For purposes of this section—

23 “(1) QUALIFIED LONG-TERM CARE EX-
24 PENSES.—

1 “(A) IN GENERAL.—The term ‘qualified
2 long-term care expenses’ means the amount
3 paid by the taxpayer during the taxable year for
4 1 or more medically necessary, diagnostic serv-
5 ices, preventive services, therapeutic services,
6 rehabilitation services, maintenance services, or
7 personal care services which are required by an
8 independent qualified person and which are pro-
9 vided in the household referred to in paragraph
10 (2)(C).

11 “(B) COVERAGE SPECIFICALLY EX-
12 CLUDED.—Such term does not include any com-
13 bination of the following kinds of coverage:

14 “(i) Basic Medicare supplement cov-
15 erage.

16 “(ii) Basic hospital-based acute care
17 expense coverage.

18 “(iii) Basic medical-surgical expense
19 coverage.

20 “(iv) Hospital confinement indemnity
21 coverage.

22 “(v) Major medical expense coverage.

23 “(vi) Disability income protection cov-
24 erage.

25 “(vii) Accident only coverage.

1 “(viii) Specified disease coverage.

2 “(ix) Specified accident coverage.

3 “(x) Limited benefit health coverage.

4 “(2) INDEPENDENT QUALIFIED PERSON.—The
5 term ‘independent qualified person’ means any indi-
6 vidual—

7 “(A) who is a parent, grandparent, or de-
8 pendent (as defined in section 152) of the tax-
9 payer,

10 “(B) who has been certified by a physician
11 as—

12 “(i) being unable to perform (without
13 substantial assistance from another indi-
14 vidual) at least 2 activities of daily living
15 (as defined in section 35(b)(2)), or

16 “(ii) having a similar level of disabil-
17 ity due to cognitive impairment, and

18 “(C) who maintains a household which is
19 his principal place of abode for more than half
20 of the taxable year of the taxpayer.

21 Such term shall not include any qualified person as
22 defined in section 35(b).”

23 (b) CLERICAL AMENDMENT.—The table of sections
24 for subpart C of part IV of subchapter A of chapter 1

1 of such Code is amended by adding at the end the follow-
 2 ing:

“Sec. 36. Credit for expenses for long-term care services provided
 to certain independent persons requiring such care.

“Sec. 37. Overpayments of tax.”

3 (c) EFFECTIVE DATE.—The amendments made by
 4 this section shall apply to taxable years beginning after
 5 December 31, 1992.

6 **Subtitle E—Treatment of** 7 **Accelerated Death Benefits**

8 **SEC. 241. TAX TREATMENT OF ACCELERATED DEATH BENE-** 9 **FITS UNDER LIFE INSURANCE CONTRACTS.**

10 (a) GENERAL RULE.—Section 101 of the Internal
 11 Revenue Code of 1986 (relating to certain death benefits)
 12 is amended by adding at the end thereof the following new
 13 subsection:

14 “(g) TREATMENT OF CERTAIN ACCELERATED
 15 DEATH BENEFITS.—

16 “(1) IN GENERAL.—For purposes of this sec-
 17 tion, any amount paid to an individual under a life
 18 insurance contract on the life of an insured who is
 19 a terminally ill individual or who is permanently con-
 20 fined to a nursing home shall be treated as an
 21 amount paid by reason of the death of such insured.

22 “(2) TERMINALLY ILL INDIVIDUAL.—For pur-
 23 poses of this subsection, the term ‘terminally ill indi-
 24 vidual’ means an individual who has been certified

1 by a physician, licensed under State law, as having
2 an illness or physical condition which can reasonably
3 be expected to result in death in 12 months or less.

4 “(3) PERMANENTLY CONFINED TO A NURSING
5 HOME.—For purposes of this subsection, an individ-
6 ual has been permanently confined to a nursing
7 home if the individual is presently confined to a
8 nursing home and has been certified by a physician,
9 licensed under State law, as having an illness or
10 physical condition which can reasonably be expected
11 to result in the individual remaining in a nursing
12 home for the rest of his life.”

13 (b) EFFECTIVE DATE.—The amendment made by
14 this section shall apply to taxable years beginning after
15 December 31, 1992.

16 **SEC. 242. TAX TREATMENT OF COMPANIES ISSUING QUALI-**
17 **FIED ACCELERATED DEATH BENEFIT RID-**
18 **ERS.**

19 (a) QUALIFIED ACCELERATED DEATH BENEFIT RID-
20 ERS TREATED AS LIFE INSURANCE.—Section 818 of the
21 Internal Revenue Code of 1986 (relating to other defini-
22 tions and special rules) is amended by adding at the end
23 thereof the following new subsection:

1 “(g) QUALIFIED ACCELERATED DEATH BENEFIT
2 RIDERS TREATED AS LIFE INSURANCE.—For purposes of
3 this part—

4 “(1) IN GENERAL.—Any reference to a life in-
5 surance contract shall be treated as including a ref-
6 erence to a qualified accelerated death benefit rider
7 on such contract.

8 “(2) QUALIFIED ACCELERATED DEATH BENE-
9 FIT RIDERS.—For purposes of this subsection, the
10 term ‘qualified accelerated death benefit rider’
11 means any rider or addendum on, or other provision
12 of, a life insurance contract which provides for pay-
13 ments to an individual on the life of an insured upon
14 such insured becoming a terminally ill individual (as
15 defined in section 101(g)(2)) or being permanently
16 confined to a nursing home (as defined in section
17 101(g)(3)).”

18 (b) DEFINITIONS OF LIFE INSURANCE AND MODI-
19 FIED ENDOWMENT CONTRACTS.—

20 (1) RIDER TREATED AS QUALIFIED ADDI-
21 TIONAL BENEFIT.—Paragraph (5)(A) of section
22 7702(f) of such Code is amended by striking “or”
23 at the end of clause (iv), by redesignating clause (v)
24 as clause (vi), and by inserting after clause (iv) the
25 following new clause:

1 “(v) any qualified accelerated death
2 benefit rider (as defined in section
3 818(g)(2)) or any qualified long-term care
4 insurance rider which reduces the death
5 benefit, or”.

6 (2) TRANSITIONAL RULE.—For purposes of ap-
7 plying section 7702 or 7702A of the Internal Reve-
8 nue Code of 1986 to any contract (or determining
9 whether either such section applies to such con-
10 tract), the issuance of a rider or addendum on, or
11 other provision of, a life insurance contract permit-
12 ting the acceleration of death benefits (as described
13 in section 101(g) of such Code) or for qualified long-
14 term care insurance (as defined in section 849(b) of
15 such Code) shall not be treated as a modification or
16 material change of such contract.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to taxable years beginning before,
19 on, or after December 31, 1992.

1 **Subtitle F—Federal National Long-**
2 **Term Care Reinsurance Cor-**
3 **poration**

4 **SEC. 251. AUTHORIZATION FOR ESTABLISHMENT OF COR-**
5 **PORATION.**

6 The Secretary of Health and Human Services (in this
7 subtitle referred to as the “Secretary”) is authorized to
8 provide, in accordance with this subtitle, for the incorpora-
9 tion of a corporation to be known as the Federal National
10 Long-Term Care Reinsurance Corporation (in this subtitle
11 referred to as the “Corporation”), which shall not be an
12 agency or establishment of the United States Government.

13 **SEC. 252. BOARD OF DIRECTORS AND OFFICERS.**

14 (a) BOARD OF DIRECTORS.—The Corporation shall
15 have a Board of Directors (in this subtitle referred to as
16 the “Board”) consisting of 9 members, of which—

17 (1) 3 shall be appointed by the President of the
18 United States, of which one shall be representative
19 of entities providing long-term care, one shall be a
20 representative from an insurer, and one shall be a
21 representative of consumers of long-term care; and

22 (2) 6 shall be elected annually by the stockhold-
23 ers of the Corporation entitled to vote for such mem-
24 bers.

1 Within the limitations of law and regulation, the Board
2 shall determine the general policies which shall govern the
3 operations of the Corporation, and shall have power to
4 adopt, amend, and repeal bylaws governing the perform-
5 ance of the powers and duties granted to or imposed upon
6 it by law.

7 (b) INITIAL BOARD.—Notwithstanding subsection
8 (a), the members described in subsection (a)(1) shall serve
9 as incorporators and are authorized to assist the Secretary
10 in taking whatever actions are necessary to incorporate
11 the Corporation.

12 (c) TERMS OF OFFICE.—The terms of office of each
13 member of the Board shall be one year, expiring on the
14 date of the annual meeting of the stockholders of the Cor-
15 poration; except that (1) in the case of a vacancy occurring
16 prior to the expiration of the term of a member, the va-
17 cancy shall be filled by the President (for members de-
18 scribed in subsection (a)(1)) or by the remaining members
19 of the Board (for other members) for the remainder of
20 such term, and (2) any member may be removed by the
21 President for good cause. Any vacancy in the Board shall
22 not affect its power.

23 (d) CHAIRMAN.—The President shall designate one
24 of the members described in subsection (a)(1) as the initial
25 Chairman of the Board. Thereafter, the members of the

1 Boards shall annually elect one of their number as Chair-
2 man.

3 (e) TREATMENT OF MEMBERS.—

4 (1) The members of the Board shall not by rea-
5 son of such membership, be deemed to be employees
6 of the United States Government. Except as pro-
7 vided in paragraph (2), each member of the Board
8 shall be entitled to receive the daily equivalent of the
9 maximum annual rate of basic pay in effect for
10 grade GS-18 of the General Schedule for each day
11 (including travel time) during which he is engaged
12 in the actual performance of duties vested in the
13 Corporation.

14 (2) Members of the Board who are full-time of-
15 ficers or employees of the United States shall receive
16 no additional pay by reason of their service on the
17 Board.

18 (f) OFFICERS.—The Corporation shall have a Presi-
19 dent and such other executive officers and employees as
20 may be appointed by the Board at rates of compensation
21 fixed by the Board, without regard to any provisions of
22 title 5, United States Code. No such executive officer may
23 receive any salary or other compensation from any source
24 other than the Corporation during the period of his em-
25 ployment by the Corporation.

1 **SEC. 253. PURPOSE AND AUTHORITY OF CORPORATION.**

2 (a) PURPOSE.—The Corporation shall confine its ac-
3 tivities to providing for the reinsurance of insurance com-
4 panies for extraordinary loss in the issuance or payment
5 of benefits for qualified long-term care insurance (as de-
6 fined in section 848(b) of the Internal Revenue Code of
7 1986). Except as may be provided by the Secretary in reg-
8 ulations, the Corporation may not refuse to provide for
9 such reinsurance for any insurance meeting the require-
10 ments of such section (other than paragraph (4)(C)(iii)
11 thereof).

12 (b) PREMIUMS.—The Corporation shall impose for
13 such reinsurance reasonable premiums which—

14 (1) are related to actuarial estimates of the
15 type and amount of financial risk assumed by the
16 Corporation, and

17 (2) in the aggregate (in conjunction with other
18 income which the Corporation may have) provide for
19 all the expenses of the Corporation.

20 (c) NO POLITICAL CONTRIBUTIONS.—The Corpora-
21 tion shall not contribute or otherwise support any political
22 party or candidate for elective public office.

23 (d) GENERAL POWERS.—Except as otherwise specifi-
24 cally provided in this subtitle, the Corporation and Board
25 shall have the powers of a corporation and board of direc-
26 tors in the State in which incorporated.

1 **SEC. 254. CAPITALIZATION.**

2 (a) COMMON STOCK.—The Corporation shall have
3 common stock, with such par value as the Board estab-
4 lishes, which shall be vested with all voting rights, each
5 share being entitled to one vote with rights of cumulative
6 voting at all elections of directors. The free transferability
7 of the common stock at all times to any person, firm, cor-
8 poration, or other entity shall not be restricted, except
9 that, as to the Corporation, it shall be transferable only
10 on the books of the Corporation. The Corporation shall
11 only issue such common stock with the approval of the
12 Secretary.

13 (b) DEBT.—

14 (1) For purposes of carrying out this subtitle,
15 the Corporation may, with the approval of the Sec-
16 retary and consistent with section 258, issue obliga-
17 tions having such maturities and bearing such rate
18 or rates and having such conditions (including sub-
19 ordination to other such obligations) as the Board
20 determines to be appropriate.

21 (2) The full faith and credit of the United
22 States is not pledged to the obligations and debts of
23 the Corporation. The Corporation shall insert appro-
24 priate language in all of its obligations issued under
25 this subsection clearly indicating that such obliga-
26 tions, together with the interest thereon, are not

1 guaranteed by the United States and do not con-
2 stitute debt or obligation of the United States or of
3 any agency or instrumentality thereof. The Corpora-
4 tion may purchase in the open market any of its ob-
5 ligations outstanding under this subsection at any
6 time and at any price.

7 (3) All obligations, participations, or other in-
8 struments issued by the Corporation shall be lawful
9 investments, and may be accepted as security for all
10 fiduciary, trust, and public funds, the investment or
11 deposit of which shall be under the authority and
12 control of the United States or any officer or officers
13 thereof.

14 **SEC. 255. EXEMPTION FROM STATE REGULATION AND TAX-**
15 **ATION.**

16 (a) TAXATION.—The Corporation, including its cap-
17 ital, reserves, surplus, security holdings, and income, shall
18 be exempt from all taxation now or hereafter imposed by
19 any State, district, Commonwealth, county, municipality,
20 or local taxing authority, except that any real property of
21 the Corporation shall be subject to such taxation to the
22 same extent according to its value as other real property
23 is taxed.

24 (b) INSURANCE REGULATION.—Except to the extent
25 specified by the Secretary in regulations, the Corporation

1 shall not be subject to any regulation under the insurance
2 laws of any State, district, or Commonwealth.

3 **SEC. 256. AUDIT AND ANNUAL REPORT.**

4 (a) AUDIT.—The Board shall provide for an annual
5 audit of the operations of the Corporation. Such audit
6 shall be conducted by a certified public accountant in ac-
7 cordance with generally accepted auditing principles (as
8 recognized by the Comptroller General).

9 (b) ANNUAL REPORT.—The Board shall report annu-
10 ally to the President and the Congress on the activities
11 of the Corporation. Such report shall include a presen-
12 tation of the financial status of the Corporation, as cer-
13 tified under the audit described in subsection (a).

14 **SEC. 257. PROTECTION OF NAME.**

15 No individual association, partnership, or corpora-
16 tion, except the Corporation, shall hereafter use the word
17 “Federal National Long-Term Care Reinsurance Corpora-
18 tion”, or any combination of such words, as the name or
19 a part thereof under which he or it shall do business. Vio-
20 lations of the foregoing sentence may be enjoined by any
21 court of general jurisdiction at the suit of the Corporation.
22 In any such suit, the Corporation may recover any actual
23 damages flowing from such violations, and, in addition,
24 shall be entitled to punitive damages (regardless of the
25 existence or nonexistence of actual damages) of not ex-

ceeding \$10,000 for each day during which such violation is committed or repealed.

SEC. 258. TERMINATION.

The Corporation shall terminate its activities not later than 10 years after the date of the enactment of this Act.

TITLE III—MALPRACTICE LIABILITY REFORM

SEC. 301. DEFINITIONS.

In this title, the following definitions shall apply:

(1) **ECONOMIC DAMAGES.**—The term “economic damages” means damages paid to compensate an individual for medical expenses, lost wages or other income, lost employment, burial expenses, and other pecuniary losses.

(2) **HEALTH CARE LIABILITY ACTION.**—The term “health care liability action” means a civil action brought against a health care provider (regardless of the theory of liability on which the action is based) in which a plaintiff alleges an injury caused by the provision of (or the failure to provide) health care services, except that such term does not include—

(A) any action in which a plaintiff alleges an intentional tort; or

1 (B) any action in which the plaintiff's sole
2 allegation is an allegation of an injury arising
3 from the use of a medical product.

4 (3) HEALTH CARE PROVIDER.—The term
5 “health care provider” means any individual or en-
6 tity that is engaged in the delivery of health care
7 services and is required under Federal or State law
8 to be licensed, certified, or accredited in order to de-
9 liver such services.

10 (4) INJURY.—The term “injury” means any ill-
11 ness, disease, or other harm that is the subject of
12 a health care liability action.

13 (5) NON-ECONOMIC DAMAGES.—The term
14 “non-economic damages” means any damages paid
15 to compensate an individual for subjective, non-mon-
16 etary losses, including pain, suffering, inconvenience,
17 mental suffering, emotional distress, loss of society
18 and companionship, loss of consortium, injury to
19 reputation, and humiliation, but does not include pu-
20 nitive damages.

21 (6) SECRETARY.—The term “Secretary” means
22 the Secretary of Health and Human Services.

23 (7) STATE.—The term “State” means each of
24 the several States, the District of Columbia, the
25 Commonwealth of Puerto Rico, the Virgin Islands,

1 Guam, American Samoa, and the Northern Mariana
2 Islands.

3 **SEC. 302. MALPRACTICE LIABILITY REFORM REQUIRE-**
4 **MENTS DESCRIBED.**

5 (a) IN GENERAL.—Subject to section 303, a State
6 meets the requirements of this section if it has enacted
7 laws, rules, or regulations relating to the treatment of
8 health care liability actions that meet the requirements of
9 subsections (b) through (h), relating to alternative dispute
10 resolution mechanisms that meet the requirements of sub-
11 section (i), and relating to quality assurance reform that
12 meet the requirements of subsection (j).

13 (b) LIABILITY SEVERAL AND NOT JOINT FOR NON-
14 ECONOMIC DAMAGES.—

15 (1) IN GENERAL.—With respect to non-eco-
16 nomic damages, the liability of each defendant in a
17 health care liability action shall be several only and
18 shall not be joint. Each defendant shall be liable
19 only for the amount of non-economic losses incurred
20 by the plaintiff that is in direct proportion to the de-
21 fendant's percentage of responsibility for the injury
22 suffered by the plaintiff (as determined by the trier
23 of fact pursuant to paragraph (2)).

24 (2) DETERMINATION OF PERCENTAGE OF RE-
25 SPONSIBILITY.—The trier of fact shall determine the

1 extent of each defendant's responsibility for the non-
2 economic injury suffered by the plaintiff, and shall
3 assign a percentage of responsibility for such injury
4 to each defendant.

5 (c) LIMITATION ON NON-ECONOMIC DAMAGES.—

6 (1) IN GENERAL.—The total amount of non-
7 economic damages that may be awarded to an indi-
8 vidual and the family members of such individual for
9 losses resulting from an injury which is the subject
10 of a health care liability action may not exceed
11 \$250,000, regardless of the number of health care
12 providers against whom the action is brought or the
13 number of actions brought with respect to the in-
14 jury.

15 (2) ADJUSTMENT FOR INFLATION.—The
16 amount referred to in paragraph (1) shall be in-
17 creased every 3rd year (beginning with the 3rd year
18 that begins after the date of the enactment of this
19 Act) in the same manner as amounts are increased
20 under section 215(i) of the Social Security Act for
21 base quarters or cost-of-living computation quarters
22 in such a year.

23 (d) MANDATORY OFFSETS FOR DAMAGES PAID BY
24 A COLLATERAL SOURCE.—

1 (1) IN GENERAL.—The total amount of dam-
2 ages received by an individual under a health care
3 liability action shall be reduced (in accordance with
4 paragraph (2)) by any other payment that has been
5 or will be made to the individual to compensate the
6 individual for the injury that was the subject of the
7 health care liability action, including payment
8 under—

9 (A) Federal or State disability or sickness
10 programs;

11 (B) Federal, State, or private health insur-
12 ance programs;

13 (C) private disability insurance programs;

14 (D) employer wage continuation programs;
15 and

16 (E) any other source of payment intended
17 to compensate such individual for such injury.

18 (2) AMOUNT OF REDUCTION.—The amount by
19 which an award of damages to an individual shall be
20 reduced under paragraph (1) shall be the total
21 amount of any payments (other than such award)
22 that have been made or that will be made to the in-
23 dividual to compensate the individual for the injury
24 that was the subject of the action.

1 (f) TREATMENT OF PAYMENTS FOR FUTURE ECO-
2 NOMIC LOSSES.—

3 (1) PROHIBITING SINGLE LUMP-SUM PAY-
4 MENT.—No health care provider shall be required to
5 make a single, lump-sum payment for damages for
6 any economic losses to be incurred after the date on
7 which judgment is entered in a health care liability
8 action, but shall be permitted to make periodic pay-
9 ments of such damages on the basis of projections
10 of the amount of costs expected to be incurred by
11 the plaintiff at appropriate intervals (as determined
12 by the trier of fact).

13 (2) USE OF ANNUITIES OR TRUSTS.—The court
14 may require a health care provider to purchase an
15 annuity or fund a reversionary trust to make peri-
16 odic payments under paragraph (1) if the court
17 finds a reasonable basis for concluding that the
18 health care provider may be unable to or will not
19 otherwise make the periodic payments.

20 (3) REQUIREMENT OF PERIODIC PAYMENT AS
21 FINAL ORDER.—The judgment of the court awarding
22 periodic payments may not be reopened at any time
23 to contest, amend, or modify the schedule or amount
24 of the payments in the absence of fraud or any other

1 basis under which a party may obtain relief from a
2 final judgment.

3 (4) LUMP-SUM PAYMENT UNDER SETTLEMENT
4 NOT PRECLUDED.—Nothing in this subsection shall
5 be construed to preclude the parties to a health care
6 liability action from entering into a settlement pro-
7 viding for a single, lump-sum payment for damages
8 described in paragraph (1).

9 (g) LIMITATION ON ATTORNEY'S FEES.—The
10 amount of attorney's fees that may be collected by the at-
11 torney for any party to a health care liability action for
12 services relating to the action may not exceed—

13 (1) 33 percent of the first \$50,000 awarded to
14 the party;

15 (2) 20 percent of the next \$100,000 awarded to
16 the party;

17 (3) 15 percent of the next \$100,000 awarded to
18 the party; and

19 (4) 10 percent of any amount in excess of
20 \$250,000 awarded to the party.

21 (h) SPECIAL PROVISION FOR CERTAIN OBSTETRIC
22 SERVICES.—

23 (1) IMPOSITION OF HIGHER STANDARD OF
24 PROOF.—In the case of a health care liability action
25 relating to services provided during labor or the de-

1 livery of a baby, if the plaintiff was not previously
2 treated for the pregnancy by the defendant health
3 care provider a court may not find that the defend-
4 ant committed malpractice and may not assess dam-
5 ages against the defendant unless the malpractice is
6 proven by clear and convincing evidence.

7 (2) APPLICABILITY TO GROUP PRACTICES OR
8 AGREEMENTS AMONG PROVIDERS.—For purposes of
9 paragraph (1), a health care provider shall be con-
10 sidered to have previously treated an individual for
11 a pregnancy if the provider is a member of a group
12 practice whose members previously treated the indi-
13 vidual for the pregnancy or is providing services to
14 the individual during labor or the delivery of a baby
15 pursuant to an agreement with another provider.

16 (i) ESTABLISHMENT OF ALTERNATIVE DISPUTE
17 RESOLUTION MECHANISMS.—

18 (1) IN GENERAL.—Each State shall have in ef-
19 fect at least one mediation or pretrial screening
20 panel that meets requirements specified in regula-
21 tions issued by the Secretary, or shall have in effect
22 another alternative dispute resolution mechanism
23 which the Secretary, in consultation with the Attor-
24 ney General, finds to be equally effective in deterring
25 the filing of frivolous health care liability actions and

1 providing fair and expeditious compensation for mer-
2 itorious health care liability claims.

3 (2) PROMULGATION OF REGULATIONS.—Sub-
4 ject to paragraph (3), the Secretary, in consultation
5 with the Administrative Conference of the United
6 States and the Attorney General, shall promulgate
7 regulations that specify the Secretary’s criteria for
8 mediation and pretrial screening panels and for eval-
9 uating the effectiveness of other alternative dispute
10 resolution mechanisms under paragraph (1).

11 (3) TOLLING OF STATUTE OF LIMITATIONS
12 DURING ALTERNATIVE PROCEDURES.—Any regula-
13 tions promulgated by the Secretary pursuant to
14 paragraph (2) shall include a requirement that a
15 State may not include any time occurring after a
16 claim is filed with a mediation or pretrial screening
17 panel or under any other alternative dispute resolu-
18 tion mechanism under paragraph (1) for purposes of
19 determining the applicability of any statute of limi-
20 tations to a health care liability action arising from
21 the injury that is the subject of the claim.

22 (j) QUALITY ASSURANCE REFORM.—

23 (1) IMPROVING THE PERFORMANCE OF STATE
24 MEDICAL BOARDS.—(A) The State, through the ap-
25 propriate health authority, shall collect, analyze and

1 supply the Secretary with information and data, as
2 specified in regulations to be promulgated by the
3 Secretary, on staffing, revenue, disciplinary actions,
4 expenditures, case-loads of the State Medical Board,
5 and use of continuing medical education programs in
6 order to demonstrate that the State medical boards
7 meet performance criteria established by the Sec-
8 retary in regulations.

9 (B) The State, through the appropriate health
10 authority, shall impose a requirement on the State
11 Medical Board to require a physician disciplined by
12 the State Medical Board to take a certain number
13 of continuing education courses as the board re-
14 quires, with educational outcome measures required,
15 in the subject areas in which the board determines
16 that the physician's knowledge is deficient.

17 (2) ALTERNATIVE PROGRAMS.—The Secretary
18 shall deem a State in compliance with the require-
19 ments of this section if (instead of complying with
20 the requirements of paragraph (1)) the State has in
21 effect a program to reduce the incidence of physician
22 negligence which the Secretary finds to be at least
23 as effective in reducing the incidence of negligence
24 as compliance with the requirements of paragraph

1 (1), in accordance with criteria established by the
2 Secretary that may include—

3 (A) requirements for risk management sys-
4 tems to be carried out by institutions providing
5 health care in the State;

6 (B) quality assurance systems, adminis-
7 tered by the State or professional bodies, which
8 review the quality of care rendered by the phy-
9 sicians of the State; or

10 (3) State programs for the promulgation of
11 standards of care in areas of medical practice in
12 which the risk of negligence is greatest.

13 **SEC. 303. WAIVER OF REQUIREMENTS FOR GOOD CAUSE OR**
14 **FOR CARRYING OUT DEMONSTRATION**
15 **PROJECTS.**

16 The Secretary may waive any of the requirements of
17 subsections (b) through (j) of section 302 for good cause
18 or to the extent necessary to enable a State to carry out
19 an experimental, demonstration, or pilot project if, in the
20 judgment of the Secretary, the project is likely to promote
21 the objectives of this title.

22 **SEC. 304. CERTIFICATION OF STATE COMPLIANCE.**

23 (a) NOTIFICATION.—

24 (1) IN GENERAL.—Not later than 6 months be-
25 fore the beginning of each year (beginning with the

1 first year that begins after the expiration of the 3-
2 year period beginning on the date of the enactment
3 of this Act), each State shall submit a notification
4 to the Secretary, with a certification by the Chief
5 Executive Officer of the State that, on the date the
6 notification is submitted, the State has enacted,
7 adopted, or otherwise has in effect laws, rules, or
8 regulations that meet the requirements of section
9 302.

10 (2) CONTENTS OF NOTIFICATION.—The notifi-
11 cation shall be accompanied by documentation to
12 support the certification required by this subsection,
13 including copies of relevant State statutes, rules,
14 procedures, regulations, judicial decisions, State con-
15 stitutional provisions, and opinions of the State At-
16 torney General, and shall contain such other infor-
17 mation, be in such form, and be submitted in such
18 manner, as the Secretary may require.

19 (b) REVIEW OF NOTIFICATION.—

20 (1) IN GENERAL.—Within 90 days after receiv-
21 ing a notification under subsection (a), the Secretary
22 shall review the notification and determine whether
23 the notification demonstrates that the State has en-
24 acted, adopted, or otherwise has in effect laws, rules,

1 or regulations that meet the requirements of section
2 302.

3 (2) APPROVAL OF NOTIFICATION.—If the Sec-
4 retary determines that the notification makes such
5 demonstration, the Secretary shall approve the noti-
6 fication.

7 (3) NOTICE OF DISAPPROVAL.—If, after review-
8 ing a State’s notification under subsection (a), the
9 Secretary determines that the notification does not
10 make the demonstration required, the Secretary
11 shall, not later than 15 days after making such de-
12 termination, provide the State with a written notice
13 specifying such determination and containing rec-
14 ommendations for revisions which would cause the
15 notification of the State to be approved.

16 (4) REVIEW OF REVISED NOTIFICATIONS.—Not
17 later than 30 days after receiving a revised notifica-
18 tion, the Secretary shall review the revised notifica-
19 tion and determine whether the notification dem-
20 onstrates that the State has enacted, adopted, or
21 otherwise has in effect laws, rules, or regulations
22 that meet the requirements of section 302. If the
23 Secretary determines that the revised notification
24 makes such a demonstration, the Secretary shall ap-
25 prove the revised notification.

1 (c) NON-COMPLIANCE.—

2 (1) FAILURE TO SUBMIT NOTIFICATION.—If a
3 State fails to submit to the Secretary a notification
4 or revised notification pursuant to this section, the
5 Secretary shall, not later than 15 days after the pe-
6 riod provided for submitting notification under this
7 section, send the State written notice of determina-
8 tion of non-compliance.

9 (2) FAILURE TO MEET REQUIREMENTS.—If the
10 Secretary determines that a revised notification sub-
11 mitted under subsection (b) does not demonstrate
12 that the State has enacted, adopted, or otherwise
13 has in effect laws, rules, or regulations that meet the
14 requirements of section 302, and disapproves the
15 State's revised notification, the Secretary shall, not
16 later than 15 days after making such determination,
17 provide the State with written notice of non-compli-
18 ance, including the determination of the Secretary
19 and the reasons therefore.

20 (3) FAILURE TO MEET REQUIREMENTS AFTER
21 INITIAL APPROVAL.—If, during any time period after
22 a notification is approved under this section, the
23 Secretary determines that the State does not have
24 currently in effect or has ceased enforcing the laws,
25 rules, or regulations upon which the notification was

1 approved, the Secretary shall, not later than thirty
2 days of making such determination provide the State
3 with written notice of such determination and with-
4 draw the approval of the notification. Such notice
5 shall specify the determination of the Secretary and
6 the reasons therefore.

7 (d) CONSULTATION WITH ATTORNEY GENERAL.—In
8 making determinations of compliance or non-compliance
9 pursuant to this section, the Secretary shall consult with
10 the Attorney General.

11 **SEC. 305. INCENTIVES THROUGH MEDICARE AND MEDIC-**
12 **AID.**

13 (a) MEDICARE INCENTIVES.—

14 (1) IN GENERAL.—Section 1886 of the Social
15 Security Act (42 U.S.C. 1395ww) is amended by
16 adding at the end the following new subsection:

17 “(j) PAYMENT INCENTIVES TO ENCOURAGE MEDI-
18 CAL MALPRACTICE LIABILITY REFORM.—

19 “(1) REDUCTION IN PAYMENTS FOR HOSPITALS
20 LOCATED IN CERTAIN STATES.—Notwithstanding
21 any other provision of this title, the Secretary shall
22 reduce each payment amount otherwise determined
23 under this section by 1 percent for discharges during
24 a cost reporting period with respect to hospitals that
25 are not located in a State which the Secretary cer-

1 tifies (pursuant to section 304 of the Health Care
2 Choice and Access Improvement Act of 1992) meets
3 the requirements of section 302 of the Health Care
4 Choice and Access Improvement Act of 1992 for the
5 cost reporting period.

6 “(2) ADDITIONAL PAYMENT FOR HOSPITALS
7 LOCATED IN STATES ENACTING REFORMS.—With re-
8 spect to hospitals that are not subject to a reduction
9 in payment under paragraph (1), the Secretary shall
10 make an additional payment for discharges during a
11 cost reporting period equal to the product of—

12 “(A) an amount equal to the total of all
13 amounts that were not paid to hospitals during
14 the cost reporting period as a result of the re-
15 ductions made under such paragraph; and

16 “(B) a percentage equal to the percentage
17 of all payments under this section during the
18 year to all hospitals that are not subject to the
19 reduction described in such paragraph that is
20 attributable to payments to that hospital.”.

21 (2) EFFECTIVE DATE.—The amendment made
22 by paragraph (1) shall apply with respect to dis-
23 charges for cost reporting periods beginning on or
24 after the first day of the first fiscal year that begins

1 after the expiration of the 3-year period beginning
2 on the date of the enactment of this Act.

3 (b) MEDICAID INCENTIVES.—

4 (1) IN GENERAL.—Section 1903 of the Social
5 Security Act (42 U.S.C. 1396b) is amended by in-
6 serting after subsection (r) the following new sub-
7 section:

8 “(s)(1)(A) In order for a State to receive payments
9 under paragraph (7) of subsection (a) for quarters in a
10 year without being subject to the reduction described in
11 subparagraph (B), the Secretary must certify (pursuant
12 to section 304 of the Health Care Choice and Access Im-
13 provement Act of 1992) that the State meets the require-
14 ments of section 302 of the Health Care Choice and Ac-
15 cess Improvement Act of 1992 for the year.

16 “(B) If a State is not certified for a year by the Sec-
17 retary under subparagraph (A), the per centum specified
18 in paragraph (7) of subsection (a) with respect to the
19 State shall be reduced by 2 percentage points for quarters
20 during the year.

21 “(2) In the case of a State that is not subject to the
22 reduction described in paragraph (1)(B) for quarters dur-
23 ing a year, the Secretary shall make an additional pay-
24 ment to the State equal to the product of—

1 “(A) an amount equal to the total of all
2 amounts that were not paid to States during the
3 year as a result of the reductions made under such
4 paragraph; and

5 “(B) a percentage equal to the percentage of all
6 payments under this section during the year to all
7 States that are not subject to the reduction de-
8 scribed in such paragraph that is attributable to
9 payments to that State.”.

10 (2) EFFECTIVE DATE.—The amendment made
11 by paragraph (1) shall apply to calendar quarters
12 beginning on or after the first January 1 that begins
13 after the expiration of the 3-year period beginning
14 on the date of the enactment of this Act.

15 **SEC. 306. APPLICABILITY OF CERTAIN PROVISIONS TO FED-**
16 **ERAL TORT CLAIMS ACT.**

17 (a) IN GENERAL.—Chapter 171 of title 28, United
18 States Code, is amended by adding at the end the follow-
19 ing new section:

20 **“§ 2681. Special rules for health care liability actions**

21 “(a) Notwithstanding any other provision of this
22 chapter, any action brought against the United States
23 under this chapter that is a health care liability action
24 shall be subject to the following:

1 “(1)(A) With respect to non-economic damages,
2 the liability of the United States shall be several
3 only and shall not be joint. The United States shall
4 be liable only for the amount of non-economic losses
5 incurred by the plaintiff that is in direct proportion
6 to the United States’ percentage of responsibility for
7 the injury suffered by the plaintiff (as determined by
8 the court pursuant to subparagraph (B)).

9 “(B) The court shall determine the extent of
10 each defendant’s responsibility for the non-economic
11 injury suffered by the plaintiff, and shall assign a
12 percentage of responsibility for such injury to each
13 defendant.

14 “(2)(A) The total amount of non-economic
15 damages that may be awarded to an individual and
16 the family members of such individual for losses re-
17 sulting from an injury which is the subject of the ac-
18 tion may not exceed \$250,000, regardless of the
19 number of defendants against whom the action is
20 brought or the number of actions brought with re-
21 spect to the injury.

22 “(B) The amount referred to in subparagraph
23 (A) shall be increased every 3rd year (beginning
24 with the 3rd year that begins after the date of the
25 enactment of this Act) in the same manner as

1 amounts are increased under section 215(i) of the
2 Social Security Act for base quarters or cost-of-liv-
3 ing computation quarters in such a year.

4 “(3)(A) The total amount of damages received
5 by an individual shall be reduced (in accordance with
6 subparagraph (B)) by any other payment that has
7 been or will be made to the individual to compensate
8 the individual for the injury that was the subject of
9 the action, including payment under—

10 “(i) Federal or State disability or sickness
11 programs;

12 “(ii) Federal, State, or private health in-
13 surance programs;

14 “(iii) private disability insurance programs;

15 “(iv) employer wage continuation pro-
16 grams; and

17 “(v) any other source of payment intended
18 to compensate such individual for such injury.

19 “(B) The amount by which an award of dam-
20 ages to an individual shall be reduced under sub-
21 paragraph (A) shall be the total amount of any pay-
22 ments (other than such award) that have been made
23 or that will be made to the individual to compensate
24 the individual for the injury that was the subject of
25 the action.

1 “(4)(A) The United States may not be required
2 to make a single, lump-sum payment for damages
3 for any economic losses to be incurred after the date
4 on which judgment is entered, but shall be permitted
5 to make periodic payments of such damages on the
6 basis of projections of the amount of costs expected
7 to be incurred by the plaintiff at appropriate inter-
8 vals (as determined by the court).

9 “(B) The United States may at its discretion
10 purchase an annuity or fund a reversionary trust to
11 make periodic payments under subparagraph (A).

12 “(C) The judgment of the court awarding peri-
13 odic payments may not be reopened at any time to
14 contest, amend, or modify the schedule or amount of
15 the payments in the absence of fraud or any other
16 basis under which a party may obtain relief from a
17 final judgment.

18 “(D) Nothing in this paragraph shall be con-
19 strued to preclude the parties to an action from en-
20 tering into a settlement providing for a single, lump-
21 sum payment for damages described in subpara-
22 graph (A).

23 “(b) In this section, the following definitions shall
24 apply:

1 “(1) The term ‘economic damages’ means dam-
2 ages paid to compensate an individual for medical
3 expenses, lost wages or other income, lost employ-
4 ment, burial expenses, and other pecuniary losses.

5 “(2) The term ‘health care liability action’
6 means a civil action brought against the United
7 States (regardless of the theory of liability on which
8 the action is based) in which a plaintiff alleges an
9 injury caused by the provision of (or the failure to
10 provide) health care services, except that such term
11 does not include—

12 “(A) any action in which a plaintiff alleges
13 an intentional tort; or

14 “(B) any action in which the plaintiff’s
15 sole allegation is an allegation of an injury aris-
16 ing from the use of a medical product.

17 “(3) The term ‘injury’ means any illness, dis-
18 ease, or other harm that is the subject of a health
19 care liability action.

20 “(4) The term ‘non-economic damages’ means
21 any damages paid to compensate an individual for
22 subjective, non-monetary losses, including pain, suf-
23 fering, inconvenience, mental suffering, emotional
24 distress, loss of society and companionship, loss of

1 consortium, injury to reputation, and humiliation,
2 but does not include punitive damages.”.

3 (b) CLERICAL AMENDMENT.—The table of sections
4 at the beginning of chapter 171 of title 28, United States
5 Code, is amended by adding at the end the following new
6 item:

“2681. Special rules for health care liability actions.”.

7 (c) EFFECTIVE DATE.—The amendments made by
8 subsections (a) and (b) shall apply to actions brought
9 against the United States on or after the date of the en-
10 actment of this Act.

11 **SEC. 307. RULES OF CONSTRUCTION.**

12 Nothing in this title may be construed to—

13 (1) waive or affect any defense of sovereign im-
14 munity asserted by any State under any law or by
15 the United States;

16 (2) preempt State choice-of-law rules with re-
17 spect to claims brought by a foreign nation or a citi-
18 zen of a foreign nation;

19 (3) affect the right of any court to transfer
20 venue, to apply the law of a foreign nation, or to dis-
21 miss a claim of a foreign nation or of a citizen of
22 a foreign nation on the ground of inconvenient
23 forum;

24 (4) create or vest jurisdiction in the district
25 courts of the United States over any health care li-

ability action subject to this Act (which is not otherwise properly in Federal district court); or

(5) prevent any State from enacting, adopting, or otherwise having in effect more comprehensive or additional health care liability reforms than those set forth in this Act.

TITLE IV—WORKING AMERICANS ACCESS TO HEALTH CARE

Subtitle A—Increase in Small Employer Access to Affordable Health Insurance

SEC. 401. ESTABLISHMENT AND ENFORCEMENT OF STANDARDS FOR SMALL EMPLOYER HEALTH INSURANCE PLANS.

(a) ESTABLISHMENT OF GENERAL STANDARDS.—

(1) ROLE OF NAIC.—The Secretary of Health and Human Services shall request the National Association of Insurance Commissioners to develop, within 1 year after the date of the enactment of this Act, model regulations that specify standards with respect to each of the following:

(A) The requirement, under section 403(a), that small employer carriers offer MedEquity plans.

1 (B) The basic benefits to be included in
2 MedEquity plans under section 403(b).

3 (C) The requirements of guaranteed issue
4 of MedEquity plans under section 403(c).

5 (D) The requirements of sections 404 and
6 405(b).

7 (E) The requirements of subsections (a)
8 and (c) of section 405.

9 If the NAIC develops such regulations specifying
10 such standards within such period, the Secretary
11 shall review such standards to determine if they
12 meet such requirements. Such review shall be com-
13 pleted within 6 months after the date the regulations
14 are developed. Unless the Secretary determines with-
15 in such period that the standards do not meet the
16 requirements, such standards shall serve as the
17 standards under this section.

18 (2) CONTINGENCY.—If the NAIC does not de-
19 velop such model regulations within such period or
20 the Secretary determines that such regulations do
21 not meet the requirements described in paragraph
22 (1), the Secretary shall inform the NAIC of the spe-
23 cific deficiencies and request the NAIC to develop
24 such model regulations in conformity with paragraph
25 (1).

1 (3) EFFECTIVE DATE.—The standards provided
2 under this subsection—

3 (A) shall apply to small employer health
4 benefit plans offered in a State on or after the
5 date the standards are implemented in the
6 State under subsection (b)(1), and

7 (B) with respect to the requirements re-
8 ferred to in paragraph (1)(D), shall apply to
9 small employer health benefit plans renewed on
10 or after 3 years after the date such standards
11 are implemented in the State under subsection
12 (b)(1).

13 (b) APPLICATION OF STANDARDS THROUGH
14 STATES.—

15 (1) APPLICATION OF ALL STANDARDS TO NEW
16 PLANS.—

17 (A) IN GENERAL.—Each State shall sub-
18 mit to the Secretary, by the deadline specified
19 in subparagraph (B), a report on the implemen-
20 tation and enforcement of the standards estab-
21 lished under subsection (a) with respect to
22 small employer health benefit plans offered not
23 later than such deadline.

24 (B) DEADLINE FOR REPORT.—

1 (i) 1 YEAR AFTER STANDARDS ESTAB-
2 LISHED.—Subject to clause (ii), the dead-
3 line under this subparagraph is 1 year
4 after the date standards are established
5 under subsection (a).

6 (ii) EXCEPTION FOR LEGISLATION.—
7 In the case of a State which the Secretary
8 identifies, in consultation with the NAIC,
9 as—

10 (I) requiring State legislation
11 (other than legislation appropriating
12 funds) in order for carriers and health
13 benefit plans offered to small employ-
14 ers to meet the standards established
15 under subsection (a), but

16 (II) having a legislature which is
17 not scheduled to meet in 1993 in a
18 legislative session in which such legis-
19 lation may be considered,

20 the date specified in this subparagraph is
21 the first day of the first calendar quarter
22 beginning after the close of the first legis-
23 lative session of the State legislature that
24 begins on or after January 1, 1993. For
25 purposes of the previous sentence, in the

1 case of a State that has a 2-year legislative
2 session, each year of such session shall be
3 deemed to be a separate regular session of
4 the State legislature.

5 (2) APPLICATION OF CONSUMER PROTECTION
6 TO ALL PLANS.—Each State shall submit to the Sec-
7 retary, by not later than 4 years after the date
8 standards are established under subsection (a), a re-
9 port on the implementation and enforcement of the
10 standards established under subparagraphs (D) and
11 (E) subsection (a)(1) with respect to small employer
12 health benefit plans renewed not later than 4 years
13 after the date such standards were established.

14 (3) MORE STRINGENT STATE STANDARDS PER-
15 MITTED.—A State may implement standards that
16 are more stringent than the standards established
17 under subsection (a).

18 (4) ENFORCEMENT.—If the Secretary deter-
19 mines that a State has failed to submit a report by
20 the deadline under paragraph (1) or (2) or finds
21 that the State no longer is carrying out its respon-
22 sibility under the respective paragraph, the Sec-
23 retary shall notify the State and provide the State
24 a period of 30 days in which to submit such report
25 or to carry out its responsibilities under the respec-

1 tive paragraph. If, after such 30-day period, the Sec-
2 retary finds that such a failure has not been cor-
3 rected, the Secretary shall provide for such mecha-
4 nism for the implementation and enforcement of the
5 standards established under subsection (a) in the
6 State as the Secretary determines to be appropriate.
7 Such standards shall apply to health benefit plans
8 offered or renewed on or after 3 months after the
9 applicable deadlines established under subpara-
10 graphs (A) through (C) of subsection (a)(3).

11 **SEC. 402. PREEMPTION OF STATE BENEFITS MANDATES**
12 **FOR PLANS THAT MEET CONSUMER PROTEC-**
13 **TION STANDARDS.**

14 (a) **FINDING.**—Congress finds that health benefit
15 plans offered with respect to small employers affect inter-
16 state commerce.

17 (b) **PREEMPTION.**—In the case of a small employer
18 health benefit plan that meets the standards with respect
19 to the requirements referred to in subparagraphs (D) and
20 (E) of section 401(a)(1), no provision of State law shall
21 apply that requires the offering, as part of the health ben-
22 efit plan with respect to such an employer, of any services,
23 category of care, or services of any class or type of pro-
24 vider.

1 **SEC. 403. REQUIREMENT FOR OFFERING OF BASIC, LOW**
2 **COST PLAN (MEDEQUITY PLAN).**

3 (a) IN GENERAL.—Each small employer carrier
4 which makes available in a State any small employer
5 health benefit plan shall make available to each small em-
6 ployer in the State a MedEquity plan (as defined in sub-
7 section (b)).

8 (b) MEDEQUITY PLAN DEFINED.—

9 (1) IN GENERAL.—In this title, except as pro-
10 vided in paragraph (2), the term “MedEquity plan”
11 means a health benefits plan that—

12 (A) is designed to provide only basic hos-
13 pital, medical, and surgical benefits, specified
14 under standards under section 401(a)(1)(B), so
15 as to make it affordable to small employers;

16 (B) is guaranteed issue (as described in
17 subsection (c));

18 (C) meets the standards established under
19 subparagraphs (D) and (E) section 401(a)(1)
20 (relating to the requirements of sections 404
21 and 405); and

22 (D) provides for cost-containment in ac-
23 cordance with the model made applicable under
24 subsection (d) in the State in which the plan is
25 issued.

1 (2) SPECIAL RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.—With respect to a carrier
2 that is a Federally-qualified health maintenance or-
3 ganization (as defined in section 1301(a) of the Pub-
4 lic Health Service Act), the term “MedEquity plan”
5 means a plan of the type described in paragraph (1)
6 but with benefits that are consistent with the re-
7 quirements for the plans of such an organization
8 under title XIII of such Act. With respect to a car-
9 rier that is not such a Federally-qualified health
10 maintenance organization but which is recognized
11 under State law as a health maintenance organiza-
12 tion, the term “MedEquity plan” means a plan of
13 the type described in paragraph (1) but with bene-
14 fits that are consistent with the requirements of
15 State law for the plans of such an organization.
16

17 (3) REVIEW OF MINIMUM BENEFIT STAND-
18 ARDS.—The NAIC is requested to periodically review
19 the standards for minimum benefits described in
20 paragraph (1)(A). The NAIC is requested to submit
21 to the Secretary and the Congress its recommenda-
22 tions on changes that should be made in such stand-
23 ards.

24 (c) GUARANTEED ISSUE FOR MEDEQUITY PLANS.—

1 (1) IN GENERAL.—Each MedEquity plan in a
2 State—

3 (A) subject to paragraph (2), must accept
4 every small employer in the State that applies
5 for coverage under the plan;

6 (B) subject to paragraphs (2) and (3),
7 must accept for enrollment every individual who
8 is a full-time employee (or, in the case of family
9 enrollment with respect to such an employee,
10 the employee's spouse and the employee's de-
11 pendents who are under 19 years of age or who
12 are full-time students and under 21 years of
13 age) who applies for enrollment on a timely
14 basis; and

15 (C) subject to paragraphs (2) and (3), may
16 not place any restriction on the eligibility of an
17 individual to enroll, so long as such an individ-
18 ual is a full-time employee or the employee's
19 spouse or dependent described in subparagraph
20 (B).

21 (2) SPECIAL RULES FOR HEALTH MAINTENANCE
22 ORGANIZATIONS.—In the case of a
23 MedEquity plan offered by a health maintenance or-
24 ganization, the plan shall—

1 (A) limit the employers that may apply for
2 coverage to those with eligible individuals resid-
3 ing in the service area of the plan,

4 (B) limit the individuals who may be en-
5 rolled under the plan to those who reside in the
6 service area of the plan, and

7 (C) within the service area of the plan,
8 deny coverage to such employers if the plan
9 demonstrates that—

10 (i) it will not have the capacity to de-
11 liver services adequately to enrollees of any
12 additional groups because of its obligations
13 to existing group contract holders and en-
14 rollees, and

15 (ii) it is applying this subparagraph
16 uniformly to all employers without regard
17 to the health status, claims experience, or
18 duration of coverage of those employers
19 and their employees.

20 (3) EXCEPTION FOR CERTAIN LATE ENROLL-
21 EES.—

22 (A) IN GENERAL.—Except as provided in
23 this paragraph, paragraph (1)(B) shall not
24 apply to an eligible employee or dependent who
25 fails to enroll in a health benefit plan during an

1 initial enrollment period, if such period is at
2 least 30 days long.

3 (B) EXCEPTION FOR THOSE WITH PRE-
4 VIOUS EMPLOYER COVERAGE.—Subparagraph
5 (A) shall not apply to an individual who—

6 (i) was covered under another em-
7 ployer health benefit plan at the time of
8 the individual's initial enrollment period,

9 (ii) stated at the time of initial enroll-
10 ment period that coverage under another
11 employer health benefit plan was the rea-
12 son for declining enrollment,

13 (iii) lost coverage under another em-
14 ployer health benefit plan as a result of
15 termination of employment, the termi-
16 nation of the other plan's coverage, death
17 of a spouse, or divorce, and

18 (iv) requests enrollment within 30
19 days after termination of coverage under
20 another employer health benefit plan.

21 (C) EXCEPTION FOR OPEN ENROLL-
22 MENT.—Subparagraph (A) shall not apply to
23 an individual who—

24 (i) is employed by an employer which
25 offers multiple health benefit plans, and

1 (ii) elects a different plan during an
2 open enrollment period.

3 (D) EXCEPTION FOR COURT ORDERS.—
4 Subparagraph (A) shall not apply to a spouse
5 or minor child if a court has ordered coverage
6 be provided for the spouse or child under a cov-
7 ered employee's health benefit plan and request
8 for such coverage is made within 30 days after
9 issuance of such court order.

10 (d) COST CONTAINMENT STANDARDS.—

11 (1) DEVELOPMENT OF MODELS.—

12 (A) ROLE OF NAIC.—The Secretary shall
13 request the NAIC to develop, within 1 year
14 after the date of the enactment of this Act,
15 models for cost-containment features in
16 MedEquity plans. Such models shall include a
17 managed care plan (described in paragraph (3))
18 and any combination of such models the NAIC
19 finds appropriate. If the NAIC develops such
20 models within such period, the Secretary shall
21 review such models to determine if they provide
22 for effective cost-containment. Such review shall
23 be completed within 6 months after the date the
24 models are developed. Unless the Secretary de-
25 termines within such period that such a model

1 does not provide effective cost-containment,
2 such remaining models shall serve as the mod-
3 els under this subsection.

4 (B) CONTINGENCY.—If the NAIC does not
5 develop such models within such period or the
6 Secretary determines that all such models do
7 not provide for effective cost-containment, the
8 Secretary shall inform the NAIC of the specific
9 deficiencies and request the NAIC to develop
10 such models in conformity with paragraph (1).

11 (2) SELECTION OF COST-CONTAINMENT MODEL
12 BY STATE.—By not later than 2 years after the date
13 of the enactment of this Act, each State shall specify
14 the cost-containment model (developed under para-
15 graph (1)) that will be applied under subsection (a)
16 to MedEquity plans issued in the State.

17 (3) MANAGED CARE PLAN DEFINED.—For pur-
18 poses of paragraph (1), the term “managed care
19 plan” includes (but is not limited to) any plan
20 that—

21 (A) arranges with selected providers for
22 the furnishing of health care services,

23 (B) provides explicit standards for the se-
24 lection of such providers,

1 (C) has formal programs for ongoing qual-
2 ity assurance and utilization review, and

3 (D) provides significant financial incentives
4 for beneficiaries to use providers and proce-
5 dures associated with the plan.

6 **SEC. 404. REQUIREMENTS RELATING TO INITIAL WRITING**
7 **OF POLICIES.**

8 (a) LIMITATIONS ON TREATMENT OF PRE-EXISTING
9 CONDITIONS.—

10 (1) IN GENERAL.—A carrier may not impose
11 (or require an employer to impose through a waiting
12 period for coverage under a health benefit policy or
13 similar requirement) a limitation or exclusion of ben-
14 efits under a small employer health benefit plan re-
15 lating to treatment of a condition based on the fact
16 that the condition pre-existed the effectiveness of the
17 policy if—

18 (A) the condition relates to a condition
19 that did not exist within 6 months before the
20 date of coverage under the plan, or

21 (B) the limitation or exclusion extends over
22 more than 12 months after the date of coverage
23 under the plan.

24 (2) PREVIOUS SATISFACTION OF PRE-EXISTING
25 CONDITION REQUIREMENT.—

1 (A) IN GENERAL.—In addition, each car-
2 rier shall waive any period applicable to a pre-
3 existing condition for similar benefits with re-
4 spect to an individual to the extent that the in-
5 dividual was covered for the condition under a
6 small employer health benefit plan that was in
7 effect before the date of the enrollment under
8 the carrier's plan.

9 (B) CONTINUOUS COVERAGE REQUIRED.—
10 Subparagraph (A) shall no longer apply if there
11 is a continuous period of more than 60 days on
12 which the individual was not covered under an
13 employer health benefit plan.

14 (b) LIMITS ON PREMIUMS.—

15 (1) LIMIT ON VARIATION OF INDEX RATES BE-
16 TWEEN BLOCKS OF BUSINESS.—

17 (A) IN GENERAL.—As a standard under
18 section 402, the index rate for a rating period
19 for any block of business of a small employer
20 carrier may not exceed the index rate for any
21 other block of business by more than 20 per-
22 cent.

23 (B) EXCEPTIONS.—Subparagraph (A)
24 shall not apply to a block of business if—

1 (i) the block is one for which the car-
2 rier does not reject, and never has rejected,
3 small employers included within the defini-
4 tion of employers eligible for the block of
5 business or otherwise eligible employees
6 and dependents who enroll on a timely
7 basis, based upon their claim experience or
8 health status,

9 (ii) the carrier does not involuntarily
10 transfer, and never has involuntarily trans-
11 ferred, a health benefit plan into or out of
12 the block of business, and

13 (iii) the block of business is currently
14 available for purchase.

15 (2) LIMIT ON VARIATION OF PREMIUM RATES
16 WITHIN A BLOCK OF BUSINESS.—For a block of
17 business of a small employer carrier, as a standard
18 under section 402 the premium rates charged during
19 a rating period to small employers with similar de-
20 mographic or other relevant characteristics (not re-
21 lating to claims experience, health status, or dura-
22 tion of coverage) for the same or similar coverage,
23 or the rates which could be charged to such employ-
24 ers under the rating system for that block of busi-

1 ness, shall not vary from the index rate by more
2 than 25 percent of the index rate.

3 (3) LIMIT ON PERMISSIBLE RATE VARI-
4 ATIONS.—Subject to paragraphs (1) and (2), as a
5 standard under section 402, a carrier may establish
6 rate variations based on factors such as geography,
7 demography, and industry and plan design.

8 (4) LIMIT ON TRANSFER OF EMPLOYERS
9 AMONG BLOCKS OF BUSINESS.—As a standard under
10 section 402, a small employer carrier may not invol-
11 untarily transfer a small employer into or out of a
12 block of business. A small employer carrier may not
13 offer to transfer a small employer into or out of a
14 block of business unless such offer is made to trans-
15 fer all small employers in the block of business with-
16 out regard to demographic characteristics, claim ex-
17 perience, health status, or duration since issue.

18 (5) DEFINITIONS.—In this subsection:

19 (A) BASE PREMIUM RATE.—The term
20 “base premium rate” means, for each block of
21 business for each rating period, the lowest pre-
22 mium rate charged or which could have been
23 charged under a rating system for that block of
24 business by the small employer carrier to small
25 employers with similar demographic or other

1 relevant characteristics (not relating to claims
2 experience, health status, or duration of cov-
3 erage) for health benefit plans with the same or
4 similar coverage.

5 (B) BLOCK OF BUSINESS.—The term
6 “block of business” means, with respect to a
7 carrier, all (or a distinct group of) small em-
8 ployers as shown on the records of the carrier.

9 (C) RULES FOR ESTABLISHING BLOCKS OF
10 BUSINESS.—For purposes of subparagraph
11 (B)—

12 (i) a carrier may establish, subject to
13 clause (ii), a distinct group of small em-
14 ployers on the basis that the applicable
15 health benefit plans either—

16 (I) are marketed and sold
17 through individuals and organizations
18 which are not participating in the
19 marketing or sale of other distinct
20 groups of small employers for the car-
21 rier,

22 (II) have been acquired from an-
23 other carrier as a distinct group, or

24 (III) are provided through an as-
25 sociation with membership of not less

1 than 100 small employers which has
2 been formed for purposes other than
3 obtaining insurance;

4 (ii) a carrier may not establish more
5 than 2 groupings under each block of busi-
6 ness because the carrier uses managed-care
7 techniques which are expected to produce
8 substantial variation in health care costs;
9 and

10 (iii) notwithstanding clauses (i) and
11 (ii), a Commissioner of Insurance of a
12 State may, upon application, approve addi-
13 tional distinct groups upon a finding that
14 such approval would enhance the efficiency
15 and fairness of the small employer market-
16 place.

17 (D) INDEX RATE.—The term “index rate”
18 means, with respect to a block of business, the
19 arithmetic average of the applicable base pre-
20 mium rate and the corresponding highest pre-
21 mium rate for the block.

22 (c) FULL DISCLOSURE OF RATING PRACTICES.—At
23 the time a carrier offers a health benefit plan to a small
24 employer, the carrier shall fully disclose to the employer
25 rating practices for small employer health benefit plans,

1 including rating practices for different industries, popu-
2 lations, and benefit designs.

3 (d) ACTUARIAL CERTIFICATION.—Each carrier shall
4 file annually with the State commissioner of insurance a
5 written statement by a member of the American Academy
6 of Actuaries (or other individual acceptable to the commis-
7 sioner) that, based upon an examination by the individual
8 which includes a review of the appropriate records and of
9 the actuarial assumptions of the carrier and methods used
10 by the carrier in establishing premium rates for applicable
11 small employer health benefit plans—

12 (1) the carrier is in compliance with the appli-
13 cable provisions of this section, and

14 (2) the rating methods are actuarially sound.

15 Each carrier shall retain a copy of such statement for ex-
16 amination at its principal place of business.

17 (e) REGISTRATION AND REPORTING.—Each carrier
18 that issues any small employer health benefit plan in a
19 State shall be registered or licensed with the State com-
20 missioner of insurance and shall comply with any report-
21 ing requirements of the commissioner relating to such a
22 plan.

23 (f) USE OF MINIMUM PARTICIPATION REQUIRE-
24 MENT.—A carrier may condition issuance, or renewal, of
25 a health benefit plan to a small employer on the enroll-

1 ment of a minimum number (or percentage) of its full-
2 time employees, in accordance with standards established
3 to carry out this section. Such standards shall require that
4 any such conditions be imposed uniformly on employers
5 of the same size.

6 **SEC. 405. REQUIREMENTS RELATING TO RENEWAL.**

7 (a) RENEWABILITY.—A carrier may not cancel a
8 small employer health benefit plan or deny renewal of cov-
9 erage under such a plan other than—

10 (1) for nonpayment of premiums,

11 (2) for fraud or other misrepresentation by the
12 insured,

13 (3) for noncompliance with plan provisions,

14 (4) for failure to maintain (in accordance with
15 standards established under section 404(f)) the
16 number of enrollees under the plan at the number
17 (or percentage) required under the plan,

18 (5) for misuse of a provider network provision,

19 or

20 (6) because the carrier is ceasing to provide any
21 small employer health benefit plan in a State, or, in
22 the case of a health maintenance organization, in a
23 geographic area.

24 (b) LIMITATION ON PREMIUM INCREASES.—A carrier
25 may not provide for an increase in the premium charged

1 a small employer for a small employer health benefit plan
2 in a percentage greater than such percentage as shall be
3 specified in standards referred to in section 401(a)(1)(E).
4 Such standards shall take into account increases in pre-
5 miums charged for new coverage of small employers under
6 the plan.

7 (c) LIMITATION ON MARKET REENTRY.—If a carrier
8 terminates the offering of health benefit plans to small
9 employers in an area, the carrier may not offer such a
10 health benefit plan to any small employer in the area until
11 5 years have elapsed since the date of the termination.

12 **SEC. 406. ESTABLISHMENT OF REINSURANCE MECHANISMS**
13 **FOR HIGH RISK INDIVIDUALS.**

14 (a) ESTABLISHMENT OF STANDARDS.—

15 (1) ROLE OF NAIC.—The Secretary shall re-
16 quest the NAIC to develop, within 1 year after the
17 date of the enactment of this Act, models for rein-
18 surance mechanisms (each in this section referred to
19 as the “reinsurance mechanism”) for individuals and
20 small employers who are enrolled under a small em-
21 ployer health benefit plan that meets the standards
22 with respect to the requirements referred to in sub-
23 paragraphs (D) and (E) of section 401(a)(1) and for
24 whom a carrier is at risk of incurring high costs

1 under the plan. Such models shall include models
2 based on each of the following:

3 (A) A voluntary prospective reinsurance
4 option.

5 (B) A retrospective reinsurance option.

6 (C) An allocation option.

7 (D) A pooled employee option.

8 (E) A designated carrier option.

9 (F) A mandatory reinsurance option.

10 If the NAIC develops such models within such pe-
11 riod, the Secretary shall review such models to deter-
12 mine if they provide for an effective reinsurance
13 mechanism. Such review shall be completed within 6
14 months after the date the models are developed. Un-
15 less the Secretary determines within such period
16 that such a model is not an effective reinsurance
17 mechanism, such remaining models shall serve as
18 the models under this section.

19 (2) CONTINGENCY.—If the NAIC does not de-
20 velop such models within such period or the Sec-
21 retary determines that all such models do not pro-
22 vide for an effective reinsurance mechanism, the
23 Secretary shall inform the NAIC of the specific defi-
24 ciencies and request the NAIC to develop such mod-
25 els in conformity with paragraph (1).

1 (b) REQUIREMENT OF IMPLEMENTATION OF REIN-
2 SURANCE MECHANISMS.—

3 (1) IN GENERAL.—By not later than 2 years
4 after the date of the enactment of this Act, each
5 State shall establish one or more reinsurance mecha-
6 nisms by not later than the deadline specified in sec-
7 tion 401(b)(1)(B) of this Act.

8 (2) DEFAULT.—If the Secretary determines
9 that a State has failed to establish any reinsurance
10 mechanism under paragraph (1), the Secretary shall
11 establish one or more such mechanisms with respect
12 to that State. The authority provided under the pre-
13 vious sentence shall expire upon the Secretary's de-
14 termination that the State has provided, by law, for
15 establishment of a reinsurance mechanism that
16 meets the requirement of paragraph (1).

17 (c) CONSTRUCTION.—Nothing in this section shall be
18 construed as to prohibit reinsurance arrangements, wheth-
19 er on a State or regional basis, not required under this
20 section.

21 **SEC. 407. REGISTRATION OF ALL HEALTH BENEFIT PLANS**
22 **REQUIRED.**

23 Notwithstanding any other provision of law, each
24 State commissioner or superintendant of insurance may,
25 under State law, require each employer health benefit plan

1 (including a self-insured plan) to be registered with such
2 official, if the plan is not otherwise required to be reg-
3 istered or licensed with the official under section 404(e),
4 and to provide the official with such information on the
5 plan as may be necessary to carry out section 406.

6 **SEC. 408. DEFINITIONS.**

7 In this subtitle:

8 (1)(A) The term “carrier” means any entity
9 which provides health insurance or health benefits in
10 a State, and includes a licensed insurance company,
11 a prepaid hospital or medical service plan, a health
12 maintenance organization, a multiple employer wel-
13 fare arrangement or employee benefits plan (as de-
14 fined under the Employee Retirement Income Secu-
15 rity Act of 1974), or any other entity providing a
16 plan of health insurance subject to State insurance
17 regulation.

18 (B) The term “small employer carrier” means
19 a carrier with respect to the issuance of a small em-
20 ployer health benefit plan.

21 (2) The term “health benefit plan” means any
22 hospital or medical expense incurred policy or certifi-
23 cate, hospital or medical service plan contract, or
24 health maintenance subscriber contract, but does not
25 include—

1 (A) accident-only, credit, dental, or disabil-
2 ity income insurance,

3 (B) coverage issued as a supplement to li-
4 ability insurance,

5 (C) worker's compensation or similar in-
6 surance, or

7 (D) automobile medical-payment insur-
8 ance.

9 (2) The term "NAIC" means the National As-
10 sociation of Insurance Commissioners.

11 (3) The term "Secretary" means the Secretary
12 of Health and Human Services.

13 (4)(A) The term "small employer" means an
14 entity actively engaged in business which, on at least
15 50 percent of its working days during the preceding
16 year, employed at least 3, but fewer than 50, full-
17 time employees. For purposes of determining if an
18 employer is a small employer, rules similar to the
19 rules of subsections (b) and (c) of section 414 of the
20 Internal Revenue Code of 1986 shall apply.

21 (B) The term "full-time employee" means, with
22 respect to an employer, an individual who normally
23 is employed for at least 30 hours per week by the
24 employer.

1 (5) The term “small employer health benefit
2 plan” means a health benefit plan which provides
3 coverage to one or more full-time employees of a
4 small employer.

5 (6) The term “State” means the 50 States, the
6 District of Columbia, and Puerto Rico.

7 (7) The term “State commissioner of insur-
8 ance” includes a State superintendent of insurance.

9 **SEC. 409. PREEMPTION FROM INSURANCE MANDATES FOR**
10 **QUALIFIED SMALL EMPLOYER PURCHASING**
11 **GROUPS.**

12 (a) **QUALIFIED SMALL EMPLOYER PURCHASING**
13 **GROUP DEFINED.**—For purposes of this section, an asso-
14 ciation is a qualified small employer purchasing group if—

15 (1) the association submits an application to
16 the Secretary of Health and Human Services at such
17 time and in such form as the Secretary may require;
18 and

19 (2) on the basis of information contained in the
20 application and any other information the Secretary
21 may require, the Secretary determines that—

22 (A) the association is administered solely
23 under the authority and control of its mem-
24 ber employers,

1 (B) the association's membership consists
2 solely of employers with not more than 100 em-
3 ployees (except that an employer member of the
4 group may retain its membership in the group
5 if, after the Secretary determines that the asso-
6 ciation meets the requirements of this para-
7 graph, the number of employees of the employer
8 member increases to more than 100),

9 (C) with respect to each State in which its
10 members are located, the association consists of
11 not fewer than 100 employers, and

12 (D) at the time the association submits its
13 application, the health benefit plans with re-
14 spect to the employer members of the associa-
15 tion are in compliance with applicable State
16 laws relating to health benefit plans.

17 (b) PREEMPTION FROM INSURANCE MANDATES.—

18 (1) FINDING.—Congress finds that employer
19 purchasing groups organized for the purpose of ob-
20 taining health insurance for employer members af-
21 fect interstate commerce.

22 (2) PREEMPTION OF STATE MANDATES.—In the
23 case of a qualified small employer purchasing group
24 described in subsection (a), no provision of State law
25 shall apply that requires the offering, as part of the

1 health benefit plan with respect to an employer
2 member of such a group, of any services, category
3 of care, or services of any class or type of provider.

4 (3) PREEMPTION OF TAXES ON PREMIUMS.—In
5 the case of a qualified small employer purchasing
6 group described in subsection (a), no provision of
7 State or local law shall apply that requires a pro-
8 vider of insurance to pay a tax on premiums received
9 from employer members of the group under a health
10 benefit plan obtained by the group from the insurer
11 for its employer members.

12 (4) PREEMPTION OF PROVISIONS RELATING TO
13 MANAGED CARE.—In the case of a qualified small
14 employer purchasing group described in subsection
15 (a), the following provisions of State law are pre-
16 empted and may not be enforced against the health
17 benefit plan with respect to an employer member of
18 such a group:

19 (A) RESTRICTIONS ON REIMBURSEMENT
20 RATES OR SELECTIVE CONTRACTING.—Any law
21 that restricts the ability of a carrier to nego-
22 tiate reimbursement rates with providers or to
23 contract selectively with one provider or a lim-
24 ited number of providers.

1 (B) RESTRICTIONS ON DIFFERENTIAL FI-
2 NANCIAL INCENTIVES.—Any law that limits the
3 financial incentives that a health benefit plan
4 may require a beneficiary to pay when a
5 nonplan provider is used on a nonemergency
6 basis.

7 (C) RESTRICTIONS ON UTILIZATION RE-
8 VIEW METHODS.—(i) Any law that—

9 (I) prohibits utilization review of any
10 or all treatments and conditions;

11 (II) requires that such review be made
12 by a resident of the State in which the
13 treatment is to be offered or by an individ-
14 ual licensed in such State, or by a physi-
15 cian in any particular specialty or with any
16 board certified specialty of the same medi-
17 cal specialty as the provider whose services
18 are being rendered;

19 (III) requires the use of specified
20 standards of health care practice in such
21 reviews or requires the disclosure of the
22 specific criteria used in such reviews;

23 (IV) requires payments to providers
24 for the expenses of responding to utiliza-
25 tion review requests; or

1 (V) imposes liability for delays in per-
 2 forming such review.

3 (ii) Nothing in clause (i)(II) shall be con-
 4 strued as prohibiting a State from requiring
 5 that utilization review be conducted by a li-
 6 censed health care professional, or requiring
 7 that any appeal from such a review be made by
 8 a licensed physician or by a licensed physi-
 9 cian in any particular specialty or with any
 10 board certified specialty of the same medical
 11 specialty as the provider whose services are
 12 being rendered.

13 (c) EFFECTIVE DATE.—This section shall take effect
 14 60 days after the date of the enactment of this Act.

15 **Subtitle B—Equalization of Tax**
 16 **Benefits for Self-employed Per-**
 17 **sons Under Certain Plans**

18 **SEC. 411. EQUALIZATION OF TAX BENEFITS FOR SELF-EM-**
 19 **PLOYED PERSONS UNDER CERTAIN PLANS.**

20 (a) INCREASE IN DEDUCTION.—Paragraph (1) of
 21 section 162(l) of the Internal Revenue Code of 1986 (re-
 22 lating to special rules for health insurance costs of self-
 23 employed individuals) is amended by striking “25 percent”
 24 and inserting “100 percent”.

1 (b) DEDUCTION MADE PERMANENT.—Subsection (l)
2 of section 162 of such Code is amended by striking para-
3 graph (6).

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to taxable years beginning after
6 December 31, 1992.

7 **Subtitle C—Managed Care Rights**

8 **SEC. 421. MANAGED CARE RIGHTS.**

9 (a) PREEMPTION OF STATE LAW PROVISIONS.—The
10 following provisions of State law are preempted and may
11 not be enforced:

12 (1) RESTRICTIONS ON REIMBURSEMENT RATES
13 OR SELECTIVE CONTRACTING.—Any law that re-
14 stricts the ability of a carrier to negotiate reimburse-
15 ment rates with providers or to contract selectively
16 with one provider or a limited number of providers.

17 (2) RESTRICTIONS ON DIFFERENTIAL FINAN-
18 CIAL INCENTIVES.—Any law that limits the financial
19 incentives that a health benefit plan may require a
20 beneficiary to pay when a non-plan provider is used
21 on a non-emergency basis.

22 (3) RESTRICTIONS ON UTILIZATION REVIEW
23 METHODS.—Any law that—

24 (A) prohibits utilization review of any or
25 all treatments and conditions,

1 (B) requires that such review be made (i)
2 by a resident of the State in which the treat-
3 ment is to be offered or by an individual li-
4 censed in such State, or (ii) by a physician in
5 any particular specialty or with any board cer-
6 tified specialty of the same medical specialty as
7 the provider whose services are being rendered,

8 (C) requires the use of specified standards
9 of health care practice in such reviews or re-
10 quires the disclosure of the specific criteria used
11 in such reviews,

12 (D) requires payments to providers for the
13 expenses of responding to utilization review re-
14 quests, or

15 (E) imposes liability for delays in perform-
16 ing such review.

17 Nothing in subparagraph (B) shall be construed as
18 prohibiting a State from (i) requiring that utilization
19 review be conducted by a licensed health care profes-
20 sional or (ii) requiring that any appeal from such a
21 review be made by a licensed physician or by a li-
22 censed physician in any particular specialty or with
23 any board certified specialty of the same medical
24 specialty as the provider whose services are being
25 rendered.

1 (b) GAO STUDY.—

2 (1) IN GENERAL.—The Comptroller General
3 shall conduct a study of the benefits and cost effec-
4 tiveness of the use of managed care in the delivery
5 of health services.

6 (2) REPORT.—By not later than 4 years after
7 the date of the enactment of this Act, the Comptrol-
8 ler General shall submit a report to Congress on the
9 study conducted under paragraph (1) and shall in-
10 clude in the report such recommendations as may be
11 appropriate.

12 **Subtitle D—Study and Report**

13 **SEC. 431. STUDY AND REPORT ON IMPACT.**

14 (a) STUDY.—The Secretary of Health and Human
15 Services shall provide for a study of the impact of the
16 changes made by this title on—

17 (1) increasing access to health care,

18 (2) the number of employees of small employers
19 who do not have health insurance coverage,

20 (3) the cost of small employer health benefit
21 plans, and

22 (4) the effectiveness of MedEquity plans.

23 (b) REPORT.—Not later than 2 years after the first
24 date provided in section 401(b), the Secretary shall submit
25 to Congress a report on the study conducted under sub-

1 section (a). The Secretary shall include in the report such
2 recommendations for changes in the provisions of this Act
3 as the Secretary deems appropriate.

4 **TITLE V—ADMINISTRATIVE**
5 **COST SAVINGS**
6 **Subtitle A—Standardization of**
7 **Claims Processing**

8 **SEC. 501. ADOPTION OF DATA ELEMENTS, UNIFORM**
9 **CLAIMS, AND UNIFORM ELECTRONIC TRANS-**
10 **MISSION STANDARDS.**

11 (a) IN GENERAL.—The Secretary of Health and
12 Human Services (in this subtitle referred to as the “Sec-
13 retary”) shall adopt standards relating to each of the fol-
14 lowing:

15 (1) Data elements for use in paper and elec-
16 tronic claims processing under health benefit plans,
17 as well as for use in utilization review and manage-
18 ment of care (including data fields, formats, and
19 medical nomenclature, and including plan benefit
20 and insurance information).

21 (2) Uniform claims forms (including uniform
22 procedure and billing codes for uses with such forms
23 and including information on other health benefit
24 plans that may be liable for benefits).

1 (3) Uniform electronic transmission of the data
2 elements (for purposes of billing and utilization re-
3 view).

4 Standards under paragraph (3) relating to electronic
5 transmission of data elements for claims for services shall
6 supersede (to the extent specified in such standards) the
7 standards adopted under paragraph (2) relating to the
8 submission of paper claims for such services. Standards
9 under paragraph (3) shall include protections to assure
10 the confidentiality of patient-specific information and to
11 protect against the unauthorized use and disclosure of in-
12 formation.

13 (b) USE OF TASK FORCES.—In adopting standards
14 under this section—

15 (1) the Secretary shall take into account the
16 recommendations of current task forces, including at
17 least the Workgroup on Electronic Data Inter-
18 change, National Uniform Billing Committee, the
19 Uniform Claim Task Force, and the Computer-based
20 Patient Record Institute;

21 (2) the Secretary shall consult with the Na-
22 tional Association of Insurance Commissioners (and,
23 with respect to standards under subsection (a)(3),
24 the American National Standards Institute); and

1 (3) the Secretary shall, to the maximum extent
2 practicable, seek to make the standards consistent
3 with any uniform clinical data sets which have been
4 adopted and are widely recognized.

5 (c) DEADLINES FOR PROMULGATION.—The Sec-
6 retary shall promulgate the standards under—

7 (1) subsection (a)(1) relating to claims process-
8 ing data, by not later than 12 months after the date
9 of the enactment of this Act;

10 (2) subsection (a)(2) (relating to uniform
11 claims forms) by not later than 12 months after the
12 date of the enactment of this Act; and

13 (3)(A) subsection (a)(3) relating to trans-
14 mission of information concerning hospital and phy-
15 sicians services, by not later than 24 months after
16 the date of the enactment of this Act, and

17 (B) subsection (a)(3) relating to transmission
18 of information on other services, by such later date
19 as the Secretary may determine it to be feasible.

20 (d) REPORT TO CONGRESS.—Not later than 3 years
21 after the date of the enactment of this Act, the Secretary
22 shall report to Congress recommendations regarding re-
23 structuring the medicare peer review quality assurance
24 program given the availability of hospital data in elec-
25 tronic form.

1 **SEC. 502. APPLICATION OF STANDARDS.**

2 (a) IN GENERAL.—If the Secretary determines, at
3 the end of the 2-year period beginning on the date that
4 standards are adopted under section 501 with respect to
5 classes of services, that a significant number of claims for
6 benefits for such services under health benefit plans are
7 not being submitted in accordance with such standards,
8 the Secretary may require, after notice in the Federal
9 Register of not less than 6 months, that all providers of
10 such services must submit claims to health benefit plans
11 in accordance with such standards. The Secretary may
12 waive the application of such a requirement in such cases
13 as the Secretary finds that the imposition of the require-
14 ment would not be economically practicable.

15 (b) SIGNIFICANT NUMBER.—The Secretary shall
16 make an affirmative determination described in subsection
17 (a) for a class of services only if the Secretary finds that
18 there would be a significant, measurable additional gain
19 in efficiencies in the health care system that would be ob-
20 tained by imposing the requirement described in such
21 paragraph with respect to such services.

22 (c) APPLICATION OF REQUIREMENT.—

23 (1) IN GENERAL.—If the Secretary imposes the
24 requirement under subsection (a)—

25 (A) in the case of a requirement that im-
26 poses the standards relating to electronic trans-

1 mission of claims for a class of services, each
2 health care provider that furnishes such services
3 for which benefits are payable under a health
4 benefit plan shall transmit electronically and di-
5 rectly to the plan on behalf of the beneficiary
6 involved a claim for such services in accordance
7 with such standards;

8 (B) any health benefit plan may reject any
9 claim subject to the standards adopted under
10 section 501 but which is not submitted in ac-
11 cordance with such standards;

12 (C) it is unlawful for a health benefit plan
13 (i) to reject any such claim on the basis of the
14 form in which it is submitted if it is submitted
15 in accordance with such standards or (ii) to re-
16 quire, for the purpose of utilization review or as
17 a condition of providing benefits under the plan,
18 a provider to transmit medical data elements
19 that are inconsistent with the standards estab-
20 lished under section 501(a)(1); and

21 (D) the Secretary may impose a civil
22 money penalty on any provider that knowingly
23 and repeatedly submits claims in violation of
24 such standards or on any health benefit plan
25 (other than a health benefit plan described in

1 paragraph (2)) that knowingly and repeatedly
2 rejects claims in violation of subparagraph (B),
3 in an amount not to exceed \$100 for each such
4 claim.

5 The provisions of section 1128A of the Social Secu-
6 rity Act (other than the first sentence of subsection
7 (a) and other than subsection (b)) shall apply to a
8 civil money penalty under subparagraph (D) in the
9 same manner as such provisions apply to a penalty
10 or proceeding under section 1128A(a) of such Act.

11 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
12 ULATION.—A plan described in this paragraph is a
13 health benefit plan—

14 (A) that is subject to regulation by a
15 State, and

16 (B) with respect to which the Secretary
17 finds that—

18 (i) the State provides for application
19 of the standards established under section
20 501, and

21 (ii) the State regulatory program pro-
22 vides for the appropriate and effective en-
23 forcement of such standards.

24 (d) TREATMENT OF REJECTIONS.—If a plan rejects
25 a claim pursuant to subsection (c)(1), the plan shall per-

1 mit the person submitting the claim a reasonable oppor-
2 tunity to resubmit the claim on a form or in an electronic
3 manner that meets the requirements for acceptance of the
4 claim under such subsection.

5 **SEC. 503. PERIODIC REVIEW AND REVISION OF**
6 **STANDARDS.**

7 (a) IN GENERAL.—The Secretary shall—

8 (1) provide for the ongoing receipt and review
9 of comments and suggestions for changes in the
10 standards adopted and promulgated under section
11 501;

12 (2) establish a schedule for the periodic review
13 of such standards; and

14 (3) based upon such comments, suggestions,
15 and review, revise such standards and promulgate
16 such revisions.

17 (b) APPLICATION OF REVISED STANDARDS.—If the
18 Secretary under subsection (a) revises the standards de-
19 scribed in 501, then, in the case of any claim for benefits
20 submitted under a health benefit plan more than the mini-
21 mum period (of not less than 6 months specified by the
22 Secretary) after the date the revision is promulgated
23 under subsection (a)(3), such standards shall apply under
24 section 502 instead of the standards previously promul-
25 gated.

1 **SEC. 504. HEALTH BENEFIT PLAN DEFINED.**

2 In this subtitle, the term “health benefit plan” has
3 the meaning given such term in section 408(2) and in-
4 cludes—

5 (1) the medicare program (under title XVIII of
6 the Social Security Act) and medicare supplemental
7 health insurance, and

8 (2) a State medicaid plan (approved under title
9 XIX of such Act).

10 **Subtitle B—Electronic Medical**
11 **Data Standards**

12 **SEC. 511. MEDICAL DATA STANDARDS FOR HOSPITALS AND**
13 **OTHER PROVIDERS.**

14 (a) PROMULGATION OF HOSPITAL DATA STAND-
15 ARDS.—

16 (1) IN GENERAL.—Between July 1, 1995, and
17 January 1, 1996, the Secretary shall promulgate
18 standards described in subsection (b) for hospitals
19 concerning electronic medical data.

20 (2) REVISION.—The Secretary may from time
21 to time revise the standards promulgated under this
22 subsection.

23 (b) CONTENTS OF DATA STANDARDS.—The stand-
24 ards promulgated under subsection (a) shall include at
25 least the following:

1 (1) A definition of a standard set of data ele-
2 ments for use by utilization and quality control peer
3 review organizations.

4 (2) A definition of the set of comprehensive
5 data elements, which set shall include for hospitals
6 the standard set of data elements defined under
7 paragraph (1).

8 (3) Standards for an electronic patient care in-
9 formation system with data obtained at the point of
10 care, including standards to protect against the un-
11 authorized use and disclosure of information.

12 (4) A specification of, and manner of presen-
13 tation of, the individual data elements of the sets
14 and system under this subsection.

15 (5) Standards concerning the transmission of
16 electronic medical data.

17 (6) Standards relating to confidentiality of pa-
18 tient-specific information.

19 The standards under this section shall be consistent with
20 standards for data elements established under section 501.

21 (c) OPTIONAL DATA STANDARDS FOR OTHER PRO-
22 VIDERS.—

23 (1) IN GENERAL.—The Secretary may promul-
24 gate standards described in paragraph (2) concern-
25 ing electronic medical data for providers that are not

1 hospitals. The Secretary may from time to time re-
2 vise the standards promulgated under this sub-
3 section.

4 (2) CONTENTS OF DATA STANDARDS.—The
5 standards promulgated under paragraph (1) for non-
6 hospital providers may include standards comparable
7 to the standards described in paragraphs (2), (4),
8 and (5) of subsection (b) for hospitals.

9 (d) CONSULTATION.—In promulgating and revising
10 standards under this section, the Secretary shall—

11 (1) consult with the American National Stand-
12 ards Institute, hospitals, with the advisory commis-
13 sion established under section 515, and with other
14 affected providers, health benefit plans, and other
15 interested parties, and

16 (2) take into consideration, in developing stand-
17 ards under subsection (b)(1), the data set used by
18 the utilization and quality control peer review pro-
19 gram under part B of title XI of the Social Security
20 Act.

21 **SEC. 512. APPLICATION OF ELECTRONIC DATA STANDARDS**
22 **TO CERTAIN HOSPITALS.**

23 (a) MEDICARE REQUIREMENT FOR SHARING OF
24 HOSPITAL INFORMATION.—As of January 1, 1997, sub-
25 ject to paragraph (2), each hospital, as a requirement of

1 each participation agreement under section 1866 of the
2 Social Security Act, shall—

3 (1) maintain clinical data included in the set of
4 comprehensive data elements under section
5 511(b)(2) in electronic form on all inpatients,

6 (2) upon request of the Secretary or of a utili-
7 zation and quality control peer review organization
8 (with which the Secretary has entered into a con-
9 tract under part B of title XI of such Act), transmit
10 electronically the data set, and

11 (3) upon request of the Secretary, or of a fiscal
12 intermediary or carrier, transmit electronically any
13 data (with respect to a claim) from such data set,
14 in accordance with the standards promulgated under sec-
15 tion 511(a).

16 (b) WAIVER AUTHORITY.—Until January 1, 2000:

17 (1) The Secretary may waive the application of
18 the requirements of subsection (a) for a hospital
19 that is a small rural hospital, for such period as the
20 hospital demonstrates compliance with such require-
21 ments would constitute an undue financial hardship.

22 (2) The Secretary may waive the application of
23 the requirements of subsection (a) for a hospital
24 that is in the process of developing a system to pro-
25 vide the required data set and executes agreements

1 with its fiscal intermediary and its utilization and
2 quality control peer review organization that the hos-
3 pital will meet the requirements of subsection (a) by
4 a specified date (not later than January 1, 2000).

5 (3) The Secretary may waive the application of
6 the requirement of subsection (a)(1) for a hospital
7 that agrees to obtain from its records the data ele-
8 ments that are needed to meet the requirements of
9 paragraphs (2) and (3) of subsection (a) and agrees
10 to subject its data transfer process to a quality as-
11 surance program specified by the Secretary.

12 (c) APPLICATION TO HOSPITALS OF THE DEPART-
13 MENT OF VETERANS AFFAIRS.—

14 (1) IN GENERAL.—The Secretary of Veterans
15 Affairs shall provide that each hospital of the De-
16 partment of Veterans Affairs shall comply with the
17 requirements of subsection (a) in the same manner
18 as such requirements would apply to the hospital if
19 it were participating in the medicare program.

20 (2) WAIVER.—Such Secretary may waive the
21 application of such requirements to a hospital in the
22 same manner as the Secretary of Health and
23 Human Services may waive under subsection (b) the
24 application of the requirements of subsection (a).

1 **SEC. 513. ELECTRONIC TRANSMISSION TO FEDERAL AGEN-**
2 **CIES.**

3 (a) IN GENERAL.—Effective January 1, 2000, if a
4 provider is required under a Federal program to transmit
5 a data element that is subject to a presentation or trans-
6 mission standard (as defined in subsection (b)), the head
7 of the Federal agency responsible for such program (if not
8 otherwise authorized) is authorized to require the provider
9 to present and transmit the data element electronically in
10 accordance with such a standard.

11 (b) PRESENTATION OR TRANSMISSION STANDARD
12 DEFINED.—In subsection (a), the term “presentation or
13 transmission standard” means a standard, promulgated
14 under subsection (b) or (c) of section 511, described in
15 paragraph (4) or (5) of section 511(b).

16 **SEC. 514. LIMITATION ON DATA REQUIREMENTS WHERE**
17 **STANDARDS ARE IN EFFECT.**

18 (a) IN GENERAL.—If standards with respect to data
19 elements are promulgated under section 511 with respect
20 to a class of provider, a health benefit plan may not re-
21 quire, for the purpose of utilization review or as a condi-
22 tion of providing benefits under the plan, that a provider
23 in the class—

24 (1) provide any data element not in the set of
25 comprehensive data elements specified under such
26 standards, or

1 (2) transmit or present any such data element
2 in a manner inconsistent with the applicable stand-
3 ards for such transmission or presentation.

4 (b) COMPLIANCE.—

5 (1) IN GENERAL.—The Secretary may impose a
6 civil money penalty on any health benefit plan (other
7 than a health benefit plan described in paragraph
8 (2)) that fails to comply with subsection (a) in an
9 amount not to exceed \$100 for each such failure.
10 The provisions of section 1128A of the Social Secu-
11 rity Act (other than the first sentence of subsection
12 (a) and other than subsection (b)) shall apply to a
13 civil money penalty under this paragraph in the
14 same manner as such provisions apply to a penalty
15 or proceeding under section 1128A(a) of such Act.

16 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
17 ULATION.—A plan described in this paragraph is a
18 health benefit plan that is subject to regulation by
19 a State, if the Secretary finds that—

20 (A) the State provides for application of
21 the requirement of subsection (a), and

22 (B) the State regulatory program provides
23 for the appropriate and effective enforcement of
24 such requirement with respect to such plans.

1 **SEC. 515. ADVISORY COMMISSION.**

2 (a) IN GENERAL.—The Secretary shall establish an
3 advisory commission including hospital executives, hospital
4 data base managers, physicians, health services research-
5 ers, and technical experts in collection and use of data
6 and operation of data systems. Such commission shall in-
7 clude, as ex officio members, a representative of the Direc-
8 tor of the National Institutes of Health, the Administrator
9 for Health Care Policy and Research, the Secretary of
10 Veterans Affairs, and the Director of the Centers for Dis-
11 ease Control.

12 (b) FUNCTIONS.—The advisory commission shall
13 monitor and advise the Secretary concerning—

14 (1) the standards established under this part,
15 and

16 (2) operational concerns about the implementa-
17 tion of such standards under this part.

18 (c) STAFF.—From the amounts appropriated under
19 subsection (d), the Secretary shall provide sufficient staff
20 to assist the advisory commission in its activities under
21 this section.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated \$2,000,000 for each of
24 fiscal years 1994 through 1998 to carry out this section.

1 **Subtitle C—Development and Dis-**
2 **tribution of Comparative Value**
3 **Information**

4 **SEC. 521. STATE COMPARATIVE VALUE INFORMATION PRO-**
5 **GRAMS FOR HEALTH CARE PURCHASING.**

6 (a) PURPOSE.—In order to assure the availability of
7 comparative value information to purchasers of health
8 care in each State, the Secretary shall determine whether
9 each State is developing and implementing a health care
10 value information program that meets the criteria and
11 schedule set forth in subsection (b).

12 (b) CRITERIA AND SCHEDULE FOR STATE PRO-
13 GRAMS.—The criteria and schedule for a State health care
14 value information program in this subsection shall be spec-
15 ified by the Secretary as follows:

16 (1) The State begins promptly after enactment
17 of this Act to develop (directly or through contrac-
18 tual or other arrangements with one or more States,
19 coalitions of health insurance purchasers, other enti-
20 ties, or any combination of such arrangements) in-
21 formation systems regarding comparative health val-
22 ues.

23 (2) The information contained in such systems
24 covers at least the average prices of common health
25 care services (as defined in subsection (d)) and

1 health insurance plans, and, where available, meas-
2 ures of the variability of these prices within a State
3 or other market areas.

4 (3) The information described in paragraph (2)
5 is made available within the State beginning not
6 later than one year after the date of the enactment
7 of this Act, and is revised as frequently as reason-
8 ably necessary, but at intervals of no greater than
9 one year.

10 (4) Not later than 6 years after the date of the
11 enactment of this Act the State has developed infor-
12 mation systems that provide comparative costs, qual-
13 ity, and outcomes data with respect to health insur-
14 ance plans and hospitals and made the information
15 broadly available within the relevant market areas.

16 Nothing in this section shall preclude a State from provid-
17 ing additional information, such as information on prices
18 and benefits of different health benefit plans, available.

19 (c) GRANTS TO STATES FOR THE DEVELOPMENT OF
20 STATE PROGRAMS.—

21 (1) GRANT AUTHORITY.—The Secretary may
22 make grants to each State to enable such State to
23 plan the development of its health care value infor-
24 mation program and, if necessary, to initiate the im-
25 plementation of such program. Each State seeking

1 such a grant shall submit an application therefore,
2 containing such information as the Secretary finds
3 necessary to assure that the State is likely to de-
4 velop and implement a program in accordance with
5 the criteria and schedule in subsection (b).

6 (2) OFFSET AUTHORITY.—If, at any time with-
7 in the 3-year period following the receipt by a State
8 of a grant under this subsection, the Secretary is re-
9 quired by section 522 to implement a health care in-
10 formation program in the State, the Secretary may
11 recover the amount of the grant under this sub-
12 section by offset against any other amount payable
13 to the State under the Social Security Act. The
14 amount of the offset shall be made available (from
15 the appropriation account with respect to which the
16 offset was taken) to the Secretary to carry out such
17 section.

18 (3) AUTHORIZATION OF APPROPRIATIONS.—
19 There are authorized to be appropriated such sums
20 as are necessary to make grants under this sub-
21 section, to remain available until expended.

22 (d) COMMON HEALTH CARE SERVICES DEFINED.—
23 In this section, the term “common health care services”
24 includes such procedures as the Secretary may specify and

1 any additional health care services which a State may wish
2 to include in its comparative value information program.

3 (e) STATE DEFINED.—In this subtitle, the term
4 “State” includes the District of Columbia, Puerto Rico,
5 the Virgin Islands, Guam, and American Samoa.

6 **SEC. 522. FEDERAL IMPLEMENTATION.**

7 (a) IN GENERAL.—If the Secretary finds, at any
8 time, that a State has failed to develop or to continue to
9 implement a health care value information program in ac-
10 cordance with the criteria and schedule in section 521(b),
11 the Secretary shall take the actions necessary, directly or
12 through grants or contract, to implement a comparable
13 program in the State.

14 (b) FEES.—Fees may be charged by the Secretary
15 for the information materials provided pursuant to a pro-
16 gram under this section. Any amounts so collected shall
17 be deposited in the appropriation account from which the
18 Secretary’s costs of providing such materials were met,
19 and shall remain available for such purposes until ex-
20 pended.

21 **SEC. 523. COMPARATIVE VALUE INFORMATION CONCERN-**
22 **ING FEDERAL PROGRAMS.**

23 (a) DEVELOPMENT.—The head of each Federal agen-
24 cy with responsibility for the provision of health insurance
25 or of health care services to individuals shall promptly de-

1 develop health care value information relating to each pro-
2 gram that such head administers and covering the same
3 types of data that a State program meeting the criteria
4 of section 521(b) would provide.

5 (b) DISSEMINATION OF INFORMATION.—Such infor-
6 mation shall be made generally available to States and to
7 providers and consumers of health care services.

8 **SEC. 524. DEVELOPMENT OF MODEL SYSTEMS.**

9 (a) IN GENERAL.—The Secretary shall, directly or
10 through grant or contract, develop model systems to facili-
11 tate—

12 (1) the gathering of data on health care cost,
13 quality, and outcome described in section 521(b)(4),
14 and

15 (2) analyzing such data in a manner that will
16 permit the valid comparison of such data among
17 providers and among health plans.

18 (b) EXPERIMENTATION.—The Secretary shall sup-
19 port experimentation with different approaches to achieve
20 the objectives of subsection (a) in the most cost effective
21 manner (relative to the accuracy and timeliness of the
22 data secured) and shall evaluate the various methods to
23 determine their relative success.

24 (c) STANDARDS.—When the Secretary considers it
25 appropriate, the Secretary may establish standards for the

1 collection and reporting of data on health care cost, qual-
 2 ity and outcomes in order to facilitate analysis and com-
 3 parisons among States and nationally.

4 (e) REPORT.—By not later than 3 years after the
 5 date of the enactment of this Act, the Secretary shall re-
 6 port to the Congress and the States on the models devel-
 7 oped, and experiments conducted, under this section.

8 (e) AUTHORIZATION OF APPROPRIATIONS.—There
 9 are authorized to be appropriated such sums as are nec-
 10 essary for each fiscal year beginning with fiscal year 1994
 11 to enable the Secretary to carry out this section, including
 12 evaluation of the different approaches tested under sub-
 13 section (b) and their relative cost effectiveness.

14 **Subtitle D—Additional Standards**
 15 **and Requirements; Research**
 16 **and Demonstrations**

17 **SEC. 531. STANDARDS RELATING TO USE OF MEDICARE**
 18 **AND MEDICAID MAGNETIZED HEALTH BENE-**
 19 **FIT CARDS; SECONDARY PAYOR DATA BANK.**

20 (a) MAGNETIZED IDENTIFICATION CARDS UNDER
 21 MEDICARE PROGRAM.—The Secretary shall adopt stand-
 22 ards relating to the design and use of magnetized medi-
 23 care identification cards in order to assist health care pro-
 24 viders providing medicare covered services to individuals—

1 (1) in determining whether individuals are eligi-
2 ble for benefits under the medicare program, and

3 (2) in billing the medicare program for such
4 services provided to eligible individuals.

5 Such cards shall be designed to be compatible with ma-
6 chines currently employed to transmit information on
7 credit cards. Such cards also shall be designed to be able
8 to be used with respect to the provision of benefits under
9 medicare supplemental policies.

10 (b) ADOPTION UNDER MEDICAID PLANS.—

11 (1) IN GENERAL.—The Secretary shall take
12 such steps as may be necessary to encourage and as-
13 sist States to design and use magnetized medicaid
14 identification cards that meet such standards, for
15 use under their medicaid plans.

16 (2) LIMITATION ON MMIS FUNDS.—In applying
17 section 1903(a)(3) of the Social Security Act, the
18 Secretary may determine that Federal financial par-
19 ticipation is not available under that section to a
20 State which has provided for a magnetized card sys-
21 tem that is inconsistent with the standards adopted
22 under subsection (a).

23 (c) MEDICARE AND MEDICAID SECONDARY PAYOR
24 DATA BANK.—The Secretary shall establish a medicare
25 and medicaid information system which is designed to pro-

1 vide information on those group health plans and other
2 health benefit plans that are primary payors to the medi-
3 care program and medicaid program under section
4 1862(b) or section 1905(a)(25) of the Social Security Act.

5 (d) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated, in equal proportions
7 from the Federal Hospital Insurance Trust Fund and
8 from the Federal Supplementary Medical Insurance Trust
9 Fund, a total of \$25,000,000 to carry out subsections (a)
10 and (c), including the issuance of magnetized cards to
11 medicare beneficiaries.

12 **SEC. 532. PREEMPTION OF STATE QUILL PEN LAWS.**

13 (a) IN GENERAL.—Effective January 1, 1995, no ef-
14 fect shall be given to any provision of State law that re-
15 quires medical or health insurance records (including bill-
16 ing information) to be maintained in written, rather than
17 electronic, form.

18 (b) SECRETARIAL AUTHORITY.—The Secretary of
19 Health and Human Services may issue regulations to
20 carry out subsection (a). Such regulations may provide for
21 such exceptions to subsection (a) as the Secretary deter-
22 mines to be necessary to prevent fraud and abuse, with
23 respect to controlled substances, and in such other cases
24 as the Secretary deems appropriate.

1 **SEC. 533. USE OF STANDARD IDENTIFICATION NUMBERS.**

2 (a) IN GENERAL.—Effective January 1, 1995, each
3 health benefit plan shall—

4 (1) for each of its beneficiaries that has a social
5 security account number, use that number as the
6 personal identifier for claims processing and related
7 purposes, and

8 (2) for each provider that has a unique identi-
9 fier for purposes of title XVIII of the Social Security
10 Act and that furnishes health care items or services
11 to a beneficiary under the plan, use that identifier
12 as the identifier of that provider for claims process-
13 ing and related purposes.

14 (b) COMPLIANCE.—

15 (1) IN GENERAL.—The Secretary may impose a
16 civil money penalty on any health benefit plan (other
17 than a health benefit plan described in paragraph
18 (2)) that fails to comply with standards established
19 under subsection (a) in an amount not to exceed
20 \$100 for each such failure. The provisions of section
21 1128A of the Social Security Act (other than the
22 first sentence of subsection (a) and other than sub-
23 section (b)) shall apply to a civil money penalty
24 under this paragraph in the same manner as such
25 provisions apply to a penalty or proceeding under
26 section 1128A(a) of such Act.

1 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
2 ULATION.—A plan described in this paragraph is a
3 health benefit plan that is subject to regulation by
4 a State, if the Secretary finds that—

5 (A) the State provides for application of
6 the requirement of subsection (a), and

7 (B) the State regulatory program provides
8 for the appropriate and effective enforcement of
9 such requirement with respect to such plans.

10 **SEC. 534. COORDINATION OF BENEFIT STANDARDS.**

11 (a) REVIEW OF COORDINATION OF BENEFIT PROB-
12 LEMS.—Between July 1, 1995, and January 1, 1996, the
13 Secretary shall determine whether problems relating to—

14 (1) the rules for determining the liability of
15 health benefit plans when benefits are payable under
16 two or more such plans, or

17 (2) the availability of information among such
18 health benefit plans when benefits are so payable,
19 cause significant administrative costs.

20 (b) CONTINGENT PROMULGATION OF STANDARDS.—

21 (1) IN GENERAL.—If the Secretary determines
22 that such problems do cause significant administra-
23 tive costs that could be significantly reduced through
24 the implementation of standards, the Secretary shall
25 promulgate standards concerning—

1 (A) the liability of health benefit plans
2 when benefits are payable under two or more
3 such plans, and

4 (B) the transfer among health benefit
5 plans of appropriate information (which may in-
6 clude standards for the use of unique identifi-
7 ers, and for the listing of all individuals covered
8 under a health benefit plan) in determining li-
9 ability in cases when benefits are payable under
10 two or more such plans.

11 (2) EFFECTIVE DATE.—The standards promul-
12 gated under paragraph (1) shall become effective on
13 a date specified by the Secretary, which date shall
14 be not earlier than one year after the date of pro-
15 mulgation of the standards.

16 (c) COMPLIANCE.—

17 (1) IN GENERAL.—The Secretary may impose a
18 civil money penalty on any health benefit plan (other
19 than a health benefit plan described in paragraph
20 (2)) that fails to comply with standards promulgated
21 under subsection (b) in an amount not to exceed
22 \$100 for each such failure. The provisions of section
23 1128A of the Social Security Act (other than the
24 first sentence of subsection (a) and other than sub-
25 section (b)) shall apply to a civil money penalty

1 under this paragraph in the same manner as such
2 provisions apply to a penalty or proceeding under
3 section 1128A(a) of such Act.

4 (2) PLANS SUBJECT TO EFFECTIVE STATE REG-
5 ULATION.—A plan described in this paragraph is a
6 health benefit plan that is subject to regulation by
7 a State, if the Secretary finds that—

8 (A) the State provides for application of
9 the standards established under subsection (b),
10 and

11 (B) the State regulatory program provides
12 for the appropriate and effective enforcement of
13 such standards with respect to such plans.

14 (d) REVISION OF STANDARDS.—If the Secretary es-
15 tablishes standards under subsection (b), the Secretary
16 may revise such standards from time to time and such
17 revised standards shall be applied under subsection (c) on
18 or after such date (not earlier than 6 months after the
19 date the revision is promulgated) as the Secretary shall
20 specify.

21 **SEC. 535. RESEARCH AND DEMONSTRATIONS.**

22 (a) DEMONSTRATIONS AND RESEARCH ON MONITOR-
23 ING AND IMPROVING PATIENT CARE.—

24 (1) The Secretary shall provide grants to quali-
25 fied entities to demonstrate (and conduct research

1 concerning) the application of comprehensive infor-
2 mation systems—

3 (A) in continuously monitoring patient
4 care, and

5 (B) in improving patient care.

6 (2) To make grants under this subsection, there
7 are authorized to be appropriated from the Federal
8 Hospital Insurance Trust Fund \$10,000,000 for
9 each fiscal year (beginning with fiscal year 1995 and
10 ending with fiscal year 1999).

11 (b) COMMUNICATION LINKS.—

12 (1) The Secretary may make grants to at least
13 two, but not more than five, community organiza-
14 tions, or coalitions of health care providers, health
15 benefit plans, and purchasers, to establish and docu-
16 ment the efficacy of communication links between
17 the information systems of health benefit plans and
18 of health care providers.

19 (2) To make grants under this subsection, there
20 are authorized to be appropriated such sums as may
21 be necessary for fiscal year 1994, to remain avail-
22 able until expended.

23 (c) REGIONAL OR COMMUNITY BASED CLINICAL IN-
24 FORMATION SYSTEMS.—

1 (1) The Secretary may make grants to at least
2 two, but not more than five, public or private non-
3 profit entities for the development of regional or
4 community-based clinical information systems.

5 (2) To make grants under this subsection, there
6 are authorized to be appropriated such sums as may
7 be necessary for fiscal year 1994, to remain avail-
8 able until expended.

9 (d) AMBULATORY CARE DATA SETS.—

10 (1) The Secretary may make grants to public or
11 private non-profit entities to develop and test, for
12 electronic medical data generated by physicians and
13 other entities (other than hospitals) that provide
14 health care services—

15 (A) the definition of a comprehensive set of
16 data elements, and

17 (B) the specification of, and manner of
18 presentation of, the individual data elements of
19 the set under subparagraph (A).

20 (2) To make grants under this subsection, there
21 are authorized to be appropriated such sums as may
22 be necessary for fiscal year 1994, to remain avail-
23 able until expended.

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